Five Hills Health Region

2009-2010
Annual Report

Table of Contents

Letter of Transmittal 4

Who We Are 5

Our Region 15

2009-2010 Performance Results 49

Future Outlook/Emerging Issues 62

Payee Disclosure 64

Management Report 71

2009-2010 Financial Report 72

Appendices 99

The Five Hills Health Region Annual Report is located on the internet at:
www.fhhr.ca

June 17, 2010

Letter of Transmittal

The Honourable Don McMorris
Minister of Health
Legislative Building
Regina SK S4S 0B3

Dear Minister McMorris,

The Five Hills Regional Health Authority is please to provide you and the residents of the health region with its 2009-2010 annual report. This report provides the audited financial statements and outlines activities and accomplishments of the Five Hills Health Region for the year ended March 31, 2010.

The Health Region continues to remain focused on the Ministry of Health's vision and strategic directions. We are committed to providing quality, accessible health services for the people we serve. During the fiscal year the region had many successes, including:

a) balanced budget – the Region continues to demonstrate sound fiscal management;

b) establishment of the Primary Health Care team in Moose Jaw, which is in keeping with the Ministry's direction of improving access to services through the delivery of primary health care teams;

c) responded to the H1N1 flu pandemic – the Region, through mass immunization clinics, immunized approximately 50% of the population through cooperation of many physician's clinics and their staff in supporting the Region's plans;

d) implemented the Colorectal Screening Program sponsored by the Saskatchewan Cancer Agency – the Five Hills Health Region is the first region to initiate the screening, with plans to expand to other regions in the province;

e) reduced surgery wait times – with no patient waiting more than 12 months for surgery;

f) completed many capital projects within the region including a renovation to the Emergency Department and Intensive Care Unit at Moose Jaw Union Hospital, made possible through the financial support of the Ministry and the Moose Jaw Health Foundation;

g) expanded the Releasing Time to Care program to the Mental Health Inpatient Unit; and

h) implemented Picture Archiving and Communication System (PACS) – this project addresses recommendations in the Patient First Review. It is a vital element in the government's strategy to modernize diagnostic services and improve the delivery of care to residents all across Saskatchewan.

Our successes can be attributed to the dedication and commitment of our employees and the medical staff. We are also grateful for the contributions made by our Volunteers and for the Foundations' efforts to ensure our communities have access to quality care.

Respectfully submitted,

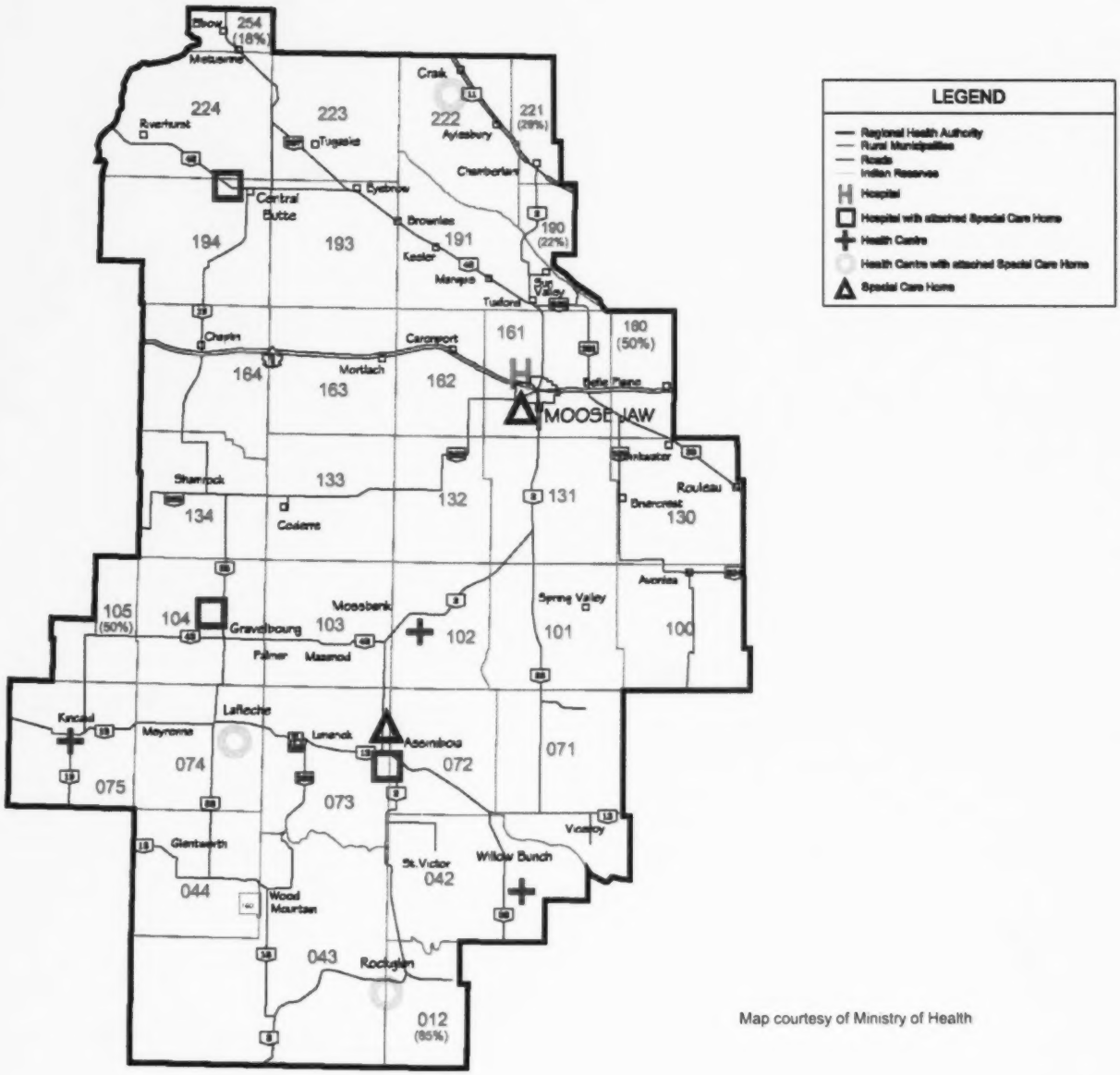
Velma Geddes, BComm, CA
Chairperson, Five Hills Regional Health Authority

Who We Are

Five Hills Health Region
Healthy Choices – Healthy People

The Region

Located in south-central Saskatchewan, the Five Hills Health Region serves a population of approximately 54,000 in an area that extends from Lake Diefenbaker to the United States border.



Map courtesy of Ministry of Health

The Authority

Velma Geddes, Chairperson, Moose Jaw
Don Shanner, Vice Chairperson, Moose Jaw
Grant Berger, Central Butte
Betty Collicott, Moose Jaw
Clark Coulson, Moose Jaw
Ken Hawkes, Moose Jaw
Al Klassen, Central Butte
Tracey Kuffner, Glentworth
Cecilia Mulhern, Meyronne
Christine Racic, Moose Jaw
George Reaves, Gravelbourg
Jeffrey Reihl, Moose Jaw

Mission

People helping people through quality services, education, teamwork, communication, community engagement and health public policy

Vision

Healthy Choices – Healthy People

Values

Respect, Trust, Honesty, Integrity, Accountability, Compassion
Dedication, Inclusion, Teamwork, Diversity, Safety, Quality
Community Focus
Patient/Client/Resident Focus
Holistic Approach
Evidenced-based Decision Making

Board Structure

The Regional Health Authority, also referred to as the Board, utilizes a Policy Leadership Model which provides for board stewardship by maintaining clear separation between governance and management, with a board focus on providing strategic leadership and oversight. The Board governs through policies that define the Board and CEO relationship. In general, key responsibilities include:

- *Stakeholder Engagement and Relationship Building*
- *Financial Stewardship*
- *Strategic Planning and Direction*
- *Quality Improvement*
- *CEO Recruitment, Evaluation and Succession Planning*
- *Maintaining Effective Governance*
- *Monitoring organizational performance and the achievement of the strategic goals*

The Board has established the following committees:

- Finance and Audit
- Governance and Human Resources
- Quality, Safety and Risk

Ethics and Standards of Conduct

In Saskatchewan, board members have legal obligations set out in *The Interpretation Act, 1995*. They are seen as fiduciaries to the corporation and thus are expected to demonstrate high standards of personal and professional conduct to maintain public confidence in their behaviours and actions. These standards include the need to avoid a conflict of interest.

A general responsibility of the members is to act in the best interest of their board. To discharge this general responsibility, the board has in place a code of conduct and ethics for all members to follow.

For the purpose of this guide, the term "code of conduct and ethics" is used in a broad sense that addresses the following issues:

- standards of behaviour, including fiduciary responsibilities and duty of care;
- conflict of interest, including both material interest and representation group interest;
- obligation to report to the board any breach of the code of conduct and ethics, or an illegal or unethical behaviour;
- protection and proper use of the board's assets and opportunities;
- confidentiality of information obtained through the members' role; and
- compliance with legislation and regulations.

The Four Pillars and Strategic Planning

The Four Pillars were developed by the Ministry of Health to outline the strategic and operational directions for the health sector. The Four Pillars are:

The Ministry and regional health authorities set out goals, key actions, measures and targets for each pillar. Additional information on the Four Pillars is attached in Appendix A.

The Board approves the strategic direction in accordance with the Ministry of Health's strategic direction and as outlined in the Accountability Document. The Board establishes policies, makes decisions and monitors performance, whereas management is focused on development of operational plans, policy options, appropriate reports to support decisions and management of operations consistent with board policy. A copy of the organizational chart is attached as Appendix B. In January 2010, the Board approved the 2010-2013 Strategic Plan.

Community Advisory Networks

The Regional Health Services Act, Section 28 states:

> *28(1) A regional health authority shall establish one or more community advisory networks for the health region for the purpose of providing the regional health authority with advice respecting the provision of health services in the health region or any portion of the health region.*
>
> *(2) The minister may provide directions to regional health authorities with respect to the establishment and composition of community advisory networks.*
>
> *(3) Persons who participate in a community advisory network are not entitled to remuneration with respect to that participation.*

The Board has a network in place for receiving advice from a number and variety of communities. Primary health care development, with its significant community development component, rounds out the existing network. The attached Appendix C provides a listing of organizations with whom the Board currently advises.

Service Responsibility

The Five Hills Health Region is responsible for:

- Acute Care (hospital)
- Long Term Care
- Home Care
- Mental Health and Addictions Services
- Public Health
- Ambulance Services
- Primary Health Care

Regional services administrative support is highly centralized in Moose Jaw. With over 1,200 full time equivalent employees, the region has efficiently organized services for finance, information technology, payroll, staff development, occupational health and safety, quality of care and risk management, privacy and communications, nutrition and food services, laundry, housekeeping, biomedical engineering, maintenance, capital planning, security, disaster planning, materials management, human resources, labour relations, recruitment and selection, as well as related administrative support.

Acute Care

Moose Jaw Union Hospital is a Tier I Regional Hospital with 100 inpatient beds which provides a range of secondary inpatient acute care services:

- Satellite Dialysis
- Anaesthesiology
- Family Medicine
- Internal Medicine
- Orthopaedics
- Paediatrics
- Emergency Medicine
- Obstetrics
- Ophthalmology
- Psychiatry
- Urology
- General Surgery
- Gynaecology
- Pathology
- Radiology
- Addictions

These services are supported by professionals in laboratory, diagnostic imaging, ultrasound, respiratory therapy, hyperbaric medicine, physical therapy, occupational therapy, pharmacy and central sterile supply.

Moose Jaw Union Hospital Statistics								
Unit	**Patient Days**		**Average Daily Census**		**Percent Occupancy**		**Average Length of Stay**	
	2010	**2009**	**2010**	**2009**	**2010**	**2009**	**2010**	**2009**
Nursery	11	13	0.03	0.04	3.01	3.56	2.2	2.17
ICU	991	1175	2.72	3.22	54.3	64.39	3.45	3.42
Women's Health	2356	2048	6.45	5.61	46.11	40.08	2.43	2.3
Paediatrics	2458	1988	6.73	5.45	67.34	54.47	2.76	2.72
Mental Health	5349	5254	14.65	14.39	104.68	102.82	15.55	13.37
Surgery	6040	5151	16.55	14.1	82.74	70.56	5.07	4.43
Medicine	12986	12816	35.53	35.11	98.69	97.53	9.06	9.12
Total Adult	30191	28445	82.67	77.93	82.67	77.93	5.9	5.8
Total Newborn	1334	1249	3.65	3.7	36.55	39.96	2.42	2.46
Total Adult and Newborn	31525	29694	86.32	81.63	78.47	74.21	5.56	5.48

Emergency Department Visits		
	2010	**2009**
Moose Jaw Union Hospital	29857	28491
Assiniboia Union Hospital	4604	4121
St. Joseph's Hospital*	4603	4894
Central Butte Regency Hospital	1000	1415

* contracted agency

The Assiniboia Union Hospital (16 beds), Assiniboia; St. Joseph's Hospital/Foyer d'Youville (9 beds), Gravelbourg and Central Butte Regency Hospital (5 beds), Central Butte are the three community hospitals in the Region. These hospitals provide acute inpatient medical care and emergency room coverage with 24/7 RN staffing. Each hospital is integrated with long term care beds, including designated respite and convalescent care.

Acute Care Facilities								
	Inpatient Days (Adult)		Average Daily Census		Percent Occupancy		Average Length of Stay	
	2010	2009	2010	2009	2010	2009	2010	2009
Moose Jaw Union Hospital	30173	28445	82.67	77.93	82.67	77.93	5.9	5.8
Assiniboia Union Hospital	5001	3999	13.7	10.96	85.63	68.48	12.4	9.5
St. Joseph's Hospital*	2223	2296	6.09	6.29	67.67	69.89	4	4.1
Central Butte Regency Hospital	478	584	1.31	2.34	26.19	46.79	21.7	17.4

*contracted agency

Long Term Care Facilities						
	Resident Days		Average Daily Census		Percent Occupancy	
	2010	2009	2010	2009	2010	2009
Central Butte Regency Hospital	7757	7486	21.3	20.5	96.6	93.23
Assiniboia Union Hospital	7971	7985	21.8	21.9	99.27	99.44
Craik and District Health Centre	5372	5305	14.7	14.5	98.12	96.89
Ross Payant Nursing Home	13279	13780	36.4	37.8	95.74	99.35
Lafleche Health Centre	5531	5754	15.2	15.8	94.71	98.53
Grasslands Health Centre	5983	6094	16.4	16.7	96.42	98.21
Extendicare*	40185	41869	110.1	114.7	88.08	91.77
Pioneers Housing	25394	25923	69.6	71	94.02	95.98
St. Joseph's Hospital*	17852	18034	48.9	49.4	97.82	98.82
Providence Place*	62721	62627	171.8	171.6	98.76	98.61

*contracted agency

Home Care/Continuing Care

Continuing Care services are generally provided to a population of frail elderly persons over the age of 75 years. The continuing care program includes home care nursing, home care personal care, home care acute care replacement services, inpatient geriatric assessment and rehabilitation, long term care, transition, convalescent, respite, palliative, and podiatry.

Institutional care is available to over 500 long term care residents, plus 14 geriatric assessment and rehabilitation, 14 transition as well as designated respite and convalescent beds. The majority of institutional long term care support is provided by affiliate organizations, Providence Place in Moose Jaw, St. Joseph Hospital/Foyer D'Youville in Gravelbourg, and Extendicare in Moose Jaw. The region provides long term care services in Rockglen, Assiniboia, Lafleche, Central Butte, and Moose Jaw.

Community based clients are further supported with day programs located at Providence Place, Central Butte, Assiniboia, and Gravelbourg.

The **Access Centre** provides continuing care services through a single point of entry. All referrals for continuing care services in the region including Home Care, Respite, Palliative Care, Long Term Care and Convalescence are managed through the Access Centre.

Mental Health and Addictions

Mental Health & Addictions Services provide acute inpatient, transitional day treatment and follow-up outpatient mental health care for children, youth and adults in both Moose Jaw and rural areas of the Five Hills Health Region.

The **Thunder Creek Rehabilitation Association** provides residential services, community supports and prevocational programs for adults experiencing severe mental illness. **The Canadian Mental Health Association** provides mental health promotion, public education and prevention information and literature on mental health and mental illness.

The health region provides a wide range of treatment options for adolescents and adults with addictions related issues. The **Angus Campbell Centre** provides a 20-bed detoxification centre for individuals over the age of 16 who are seeking assistance to withdrawal from alcohol and or other drugs. The centre provides two transition beds for clients who are waiting for Residential Addictions Treatment.

Mental Health promotion and education programs and programs for prevention of substance abuse are available for the public and human services professionals.

All services and programs may be accessed through Mental Health & Addictions Centralized Intake program. Centralized Intake responds to all initial requests for mental health and addictions information or services from individuals, family physicians, family members or community agency members.

Primary Health Care

The purpose of Primary Health Care (PHC) Team development is transformation of the healthcare system to customer-centric, integrated, quality care delivered by the right providers in the right place, at the right time.

PHC has aligned its operational plan with the Four Pillars. Individual PHC teams will develop actions to work on advancing the goals. The five Primary Health Care strategies in Five Hills Health Region are:

- Delighting our Customers
- Creating a Learning Environment
- Thinking Lean and Being Lean
- Marketing Lean Six Sigma
- Sustaining the Change

PHC teams provide physician and nurse practitioner services in Central Butte, Craik, Assiniboia (along with visiting services to Rockglen, Willowbunch, Mossbank), Kincaid and Moose Jaw. A variety of other healthcare professionals are part of each of these teams based on the needs of the population being served in the area and the community development work that is underway. Some teams include members other than healthcare providers depending upon the community needs.

Public Health Services

Public Health Services (PHS) focuses on prevention (both primary and secondary), health protection, and population health promotion. Under the leadership of the Medical Health Officer and Public Health Director, PHS provides a range of services and programs, including:

- public health nursing
- public health inspection
- early childhood psychology
- public health nutrition
- dental health education
- epidemiology & statistical analysis capacity
- population health promotion
- speech and language therapy
- Kids First Community Developers
- Teen Wellness Clinic
- Parent Mentoring Program
- Needle Exchange Program (NEP)

Increasing emphasis is being placed on the Voice of the Customer in obtaining input as to health status assessment, and ultimately the delivery of appropriate, effective, safe, responsive, efficient, and equitable public health services. Immigrant and specifically refugee health, as well as high risk clients/families, the pregnant adolescent, and injection drug users are given specific attention, as part of a comprehensive Primary Health Care approach. Services are delivered in a collaborative and consultative milieu with a vision for continuous quality improvement.

Immunization programs have been expanded, with the addition or enhancement of vaccine programs including human papillomavirus, varicella, pneumococcal (Pn-13), influenza (seasonal/ H1N1 human swine influenza), mumps, and enhanced pertussis vaccine coverage (to specified cohorts).

Health promotion efforts are embracing, amongst others, promotion of physical activity and safety promotion (ie. falls prevention), and development of a Regional Tobacco Strategy, in concert with the draft Provincial Tobacco Strategy. Needs assessments and surveys are utilized to further our knowledge about community health status.

A provincial HIV strategy is in the developmental stage; one of the pillars is harm reduction which emphasizes a strong Primary Health Care component to the delivery of a broad range of services to Needle Exchange Program clients and others.

Services include response to outbreaks of any type, comprising predominantly infectious diseases such as respiratory and enteric disease outbreaks. PHS forms part of the Health Region's emergency response capability. Pandemic planning has been ongoing in the areas of surveillance, mass immunization and infection control as it relates to a major communicable disease outbreak.

Ambulance Services (EMS)

Emergency Medical Services (EMS) are provided under contract to the Five Hills Health Region by Moose Jaw and District EMS, Hutch Ambulance Services and St. Joseph's Hospital.

Health Care Organizations

The Region either directly delivers health services through its staff, or contracts with other agencies for the provision of services. These contracted agencies are referred to as Health Care Organizations and include all private sector, community-based and affiliated (religious-based) service agencies that provide ambulance, addiction, mental health, long term care and acute services. Health Care Organizations are accountable through and to the Five Hills Health Region. Contracts are with the following health care organizations and private providers to deliver health services:

Angus Campbell Centre operates a 20-bed residential (social) detox centre for drugs and alcohol.

Canadian Mental Health Association provides community education and awareness of mental illness.

Extendicare operates a 125-bed long term care facility in Moose Jaw.

Hutch Ambulance Services provides ground ambulance services for Assiniboia and area.

Moose Jaw and District EMS provides ground ambulance services for Moose Jaw and area and Central Butte and area.

Providence Place operates a 160-bed long term care facility, a 14-bed Geriatric Assessment and Rehabilitation Unit and an adult day program, located in Moose Jaw.

St. Joseph's Hospital/Foyer d'Youville operates a 50-bed long term care and 9-bed acute care facility in Gravelbourg and provides ground ambulance services in Gravelbourg and area.

Thunder Creek Rehabilitation Association provides residential services and programs for adults with severe and persistent mental illness.

Regional Facilities

Acute Care

Moose Jaw Union Hospital (Regional Hospital)

Integrated Acute and Long Term Care

Assiniboia Union Hospital
Central Butte Regency Hospital
St. Joseph's Hospital/Foyer d'Youville *

Long Term Care

Ross Payant Nursing Home
Pioneers Lodge
Providence Place*

Integrated Long Term Care and Health Centres

Craik and District Health Centre
Grasslands Health Centre
Lafleche and District Health Centre

Wellness Centres

Mossbank Wellness Centre
Willowbunch Wellness Centre
Kincaid Wellness Centre

Affiliate and Contracted Agencies

Providence Place*
Extendicare

Moose Jaw Union Hospital

Providence Place

*Affiliate

Our Region

Introduction

The Five Hills Health Region (FHHR) has prepared a summary health status report ("Regional Environmental Scan") for the population served. This report provides a convenient snap-shot of health-status information, which can be useful when one needs to quickly provide essential statistics. It is not meant to be a thorough nor exhaustive health status report.

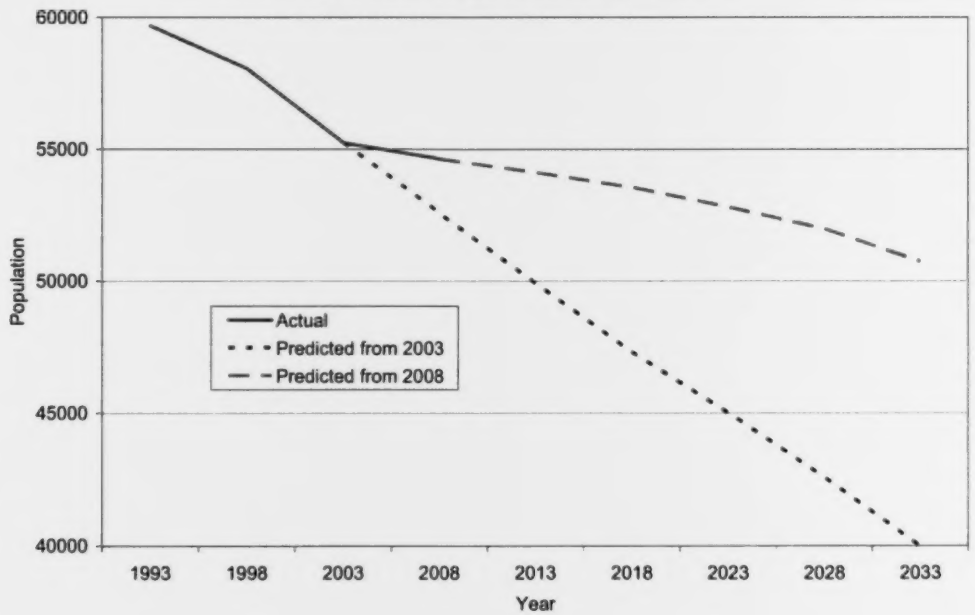
The Ministry of Health has undertaken to provide a detailed Health Status Report for individual health regions tentatively planned for release in the fall of 2011.

FHHR indicators were derived from the Canadian Institute of Health Information's (CIHI) Structural Framework of Health Indicators relating to the four broad categories of Health Status, Non-Medical Determinants of Health, Health System Performance, and Community and Health System Characteristics. Data sources include the Ministry of Health, Five Hills Health Region Department of Public Health Services, regional hospitals, Canadian Community Health Survey (CCHS), Statistics Canada, and the Canadian Institute for Health Information (CIHI). Data more current than the year 2008 is generally not yet available.

Demographics

The City of Moose Jaw accounts for the largest portion (63.5%) of the Region population. The population of the FHHR as of 2008 was 54,674. About 22% of the FHHR residents live in towns and villages, and 14% live in RMs.

Population Projection 1993-2033



A. Health Status

Well Being

Perceived Health is a widely used measure of general health. One of the methods governments use to assess the positive aspects of health is to survey the population's self-perceived health status.

From 2003-2007, female perception of health was always lower than that of males. Males and females lowest rate of perceived health was in 2007 (55.2% for male and 52% for female). After 2007, the trend changed and the female perception of health was higher than that of males (57.1% for male and 61.0% for female). (Source: CCHS)

Perceived Mental Health is a general indication of the number of people in the population suffering from some form of mental disorder, mental or emotional problems or distress, not necessarily reflected in self-perceived health. The World Health Organization defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Perceived mental health is a subjective measure of overall mental health status.

The perceived mental health of males was generally higher than that of females except for 2003-2004. The perceived mental health for males in 2008 was 78.1%. The perceived mental health for females in 2008 was 73.3%. (Source: CCHS)

Perceived Life Stress is a common aspect of life and can have negative consequences for health. These consequences include direct impacts on mental health and the onset and progression of physical illness. In addition, stress may also influence health indirectly through health behaviors such as smoking, drug use, and excessive eating and alcohol related behaviors. The degree of stress was measured by the percentage of the population aged 15 or older who reported most days to be "quite a bit stressful" or "extremely stressful" versus "not at all stressful.

Females were more likely than males to report that most days were at least quite a bit stressful from 2003 to 2008. (Source: CCHS)

Health Conditions

Body Mass Index (BMI) is a common method of determining if an individual's weight is in a healthy range based on their height. BMI is calculated as follows: weight in kilograms divided by height in meters squared. The index is:

Under 18.5	18.5-24.9	25-29.9	Greater than 30.0
underweight	acceptable weight	some excess weight	overweight

The index is calculated for those aged 20 to 64 years old excluding pregnant women and persons less than 3 feet (0.914 meters) tall or greater than 6 feet 11 inches (2.108 meters).

2008 Rates of Overweight and Obese

2008	Overweight FHHR	Obese FHHR	Overweight SK	Obese SK
Total	33.4	19.4	34.1	25.6
Male	36.2	20.1	39.5	27.7
Female	30.5	18.6	28.6	23.3

Approximately 53% of FHHR residents (aged 12 years and older) were overweight to some degree. (Source: CCHS) We can compare this to an actual Anthropometric survey undertaken in FHHR:

In May of 2007, the Region conducted an Adult and Senior Needs and Anthropometric Assessment of a resident survey group, as well as physical activity levels, and pain-scores. Some of the findings include:

- 48% of participants are not participating in enough physical activity;
- 21% of participants need to improve their body strength;
- 50% of participants need to improve their physical endurance capacity;
- 34% of participants need to improve their flexibility;
- 9% of participants do not eat breakfast;
- 21% of participants are sedentary; and
- 80% of participants have minimal or no disability.

From the above, based on BMI measurement, 64.4% (almost two-thirds) of participants surveyed are carrying at least some excess weight. To get a more accurate picture of the health risk associated with excess weight, Health Canada recommends using both BMI and Waist Circumference simultaneously. This enables us to classify the associated risk to health. This is visualized in the following table:

BMI and Waist Circumference	Normal BMI (19.5--24.9)	Overweight (25.0--29.9)	Obese (30.0+)
Acceptable for Males <102cm	Least risk-33%	Increased risk -0	High risk -0
Unhealthy for Males ≥102cm	Increased risk -0	High risk -29%	Very high risk -38%
Acceptable for Females <88cm	Least risk-26%	Increased risk -0	High risk -0
Unhealthy for Females ≥88cm	Increased risk -6%	High risk -37%	Very high risk -28%
Acceptable Total	Least risk -28%	Increased risk -0	High risk -0
Unhealthy Total	Increased risk -4%	High risk -35%	Very high risk -30%

This means that almost 70% of survey participants in the health region were at least at some increased risk of developing type 2 diabetes, coronary heart disease, hypertension, dyslipidaemia, gallbladder disease, and obstructive sleep apnea. Referral is made in the Population Health Promotion Report, of ongoing activities to promote physical activities in the FHHR. (Source: FHHR)

Arthritis is a group of conditions involving damage to the joints of the body. Arthritis is a disease of the elderly, but children can also be affected. More than 70% of individuals in North America affected by some type or arthritis are over the age of 65. Arthritis is more common in women than men at all ages and affects all races, ethnic groups and cultures.

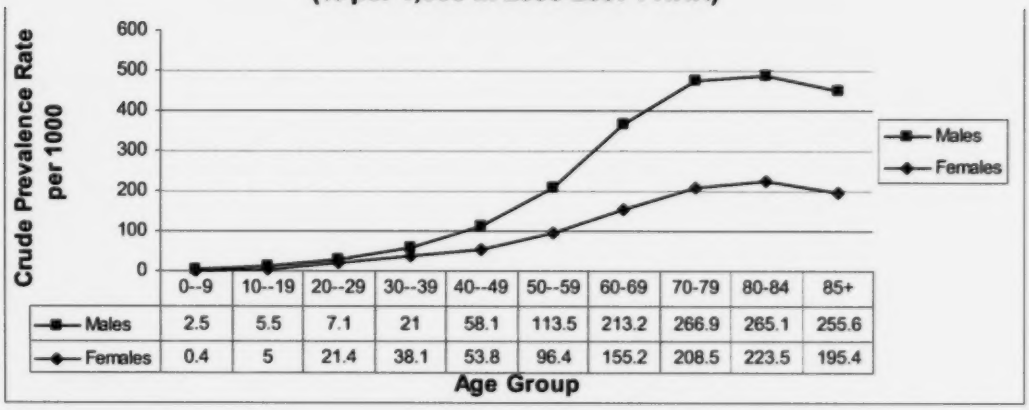
As of 2008, the percentage of arthritis in FHHR was nearly identical to that of Saskatchewan. (Source: CCHS)

High Blood Pressure, also known as hypertension, affects one in five Canadians. It is the number one risk factor for stroke and a major risk factor for heart disease, so it is very important that it is properly controlled.

In FHHR, the female prevalence rate was higher than that of males from 2003-2007. In 2008, the trend of hypertension reversed itself and female prevalence rate was lower than that of male. The percentage of hypertensive males in FHHR was higher than the percentage in SK in 2008; however, for females the percentage is lower in the FHHR than in the Province. (Source: CCHS)

Diabetes has been defined as: **"If a Saskatchewan resident has one hospitalization record or two physician visit records or one record of anti-diabetic agent prescription, then he/she becomes a case"** (MoH, April 2010)[1]. Diabetes may lead to reduced quality of life as well as complications such as heart disease, stroke, and kidney disease. Hospitalizations due to diabetes are distributed through the lifespan from youth to old age. In Saskatchewan, the overall prevalence rate of diabetes was 3.7% in 1996. In 2001, the Saskatchewan prevalence rate of diabetes had risen to 4.1% and in 2004 the prevalence had risen again, to 6.1%. It decreased to 5.8% in 2005. The likelihood of having diabetes increases with age.

Age Specific/Gender Specific Diabetes Prevalence (% per 1,000 in 2006-2007 FHHR)



	0--9	10--19	20--29	30--39	40--49	50--59	60-69	70-79	80-84	85+
Males	2.5	5.5	7.1	21	58.1	113.5	213.2	266.9	265.1	255.6
Females	0.4	5	21.4	38.1	53.8	96.4	155.2	208.5	223.5	195.4

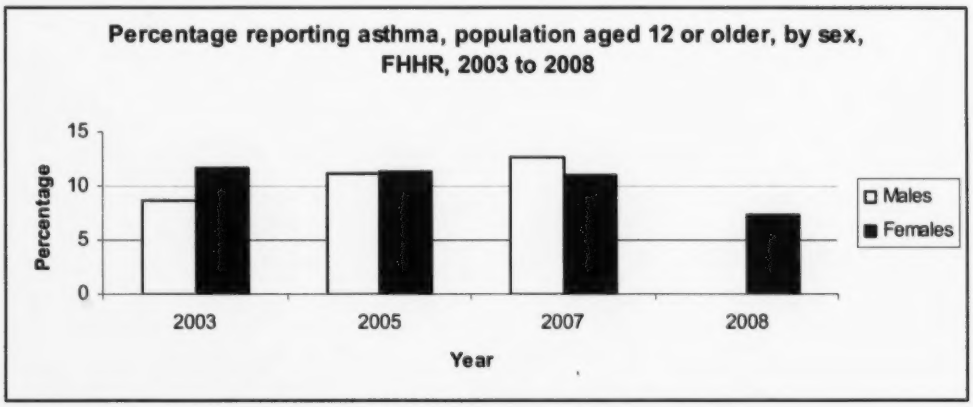
FHHR Crude Prevalence Rate per 1,000 from 2003/04-2006/07

2003-2004	2004-2005	2005-2006	2006-2007
60.7	65.7	72	78.9

[1] A diabetes case was defined as a person discharged from hospital with a diagnosis of diabetes (ICD-9: 250, ICD-10-CA: E10, E11, E13, E14) or seen twice by a physician within a period of two years with a diagnosis of diabetes (ICD-9: 250) or one or more prescriptions for insulin or an oral hypoglycaemic agent. Women with an obstetric diagnosis (based on the ICD-9 AND ICD-10-CA codes) within 120 days prior to and 90 days following a diagnosis of ICD-9 250 or ICD-10-CA E10, E11, E13, E14 to rule out gestational diabetes were not included as cases. There were two specific limitations: 1) There could have been missing data, as the physicians who are on alternative payment arrangements may not shadow bill consistently; 2) The Prescription drug information was not available for Saskatchewan residents with Registered Indian status.

[2] Age-sex adjusted rate is calculated by standardization with Canada Census 1991 standard population.

Asthma is a predisposition to chronic inflammation of the lungs in which the airways (bronchi) are reversibly narrowed. Asthma is excessively common among the individuals (up to 10% in adults and 35% in children). Asthma is differently distributed in the world. It affects 7% of the population of the United States, 6.5% of British people and a total of 300 million worldwide. Asthma causes 4,000 deaths a year in the United States. Children are more likely to present with asthma than adults.



Females were more likely than males to have asthma from 2003 to 2005. In 2007, the prevalence rate for males was higher than that for females. Data is not available for males in 2008. (Data for asthma in age group distribution in FHHR is not available.) (Source: CCHS)

Hepatitis C affects approximately 4 million or 2% of Americans, and more than 100 million persons worldwide. Chronic hepatitis C can progress to cirrhosis and liver cancer. End-stage liver disease and liver cancer due to hepatitis C account for 30%-50% of adult liver transplantations in western countries. Most people with chronic hepatitis C do not have symptoms and are not diagnosed until they have advanced liver disease.

Year	# of Incident (New) Cases	Covered Population	Hep C Rate Per 100,000
2005	20	55,476	36
2006	21	53,921	39
2007	27	53,878	50
2008	17	54,674	31
2009	16	54,674	29

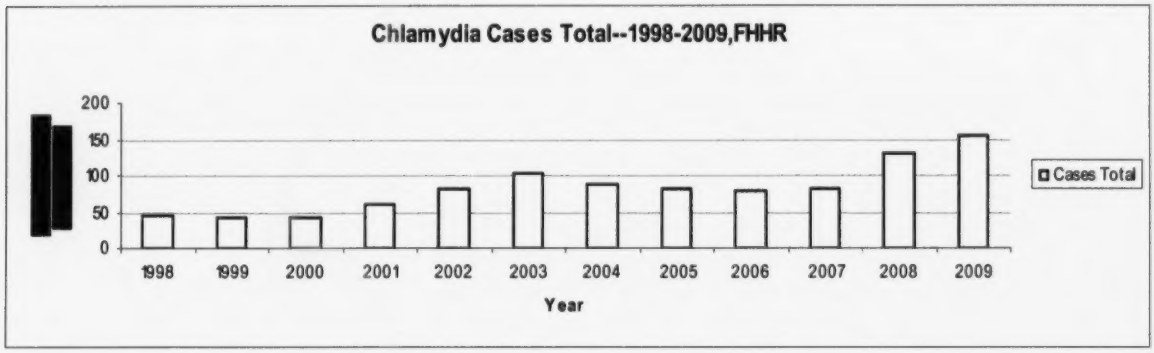
Source: FHHR

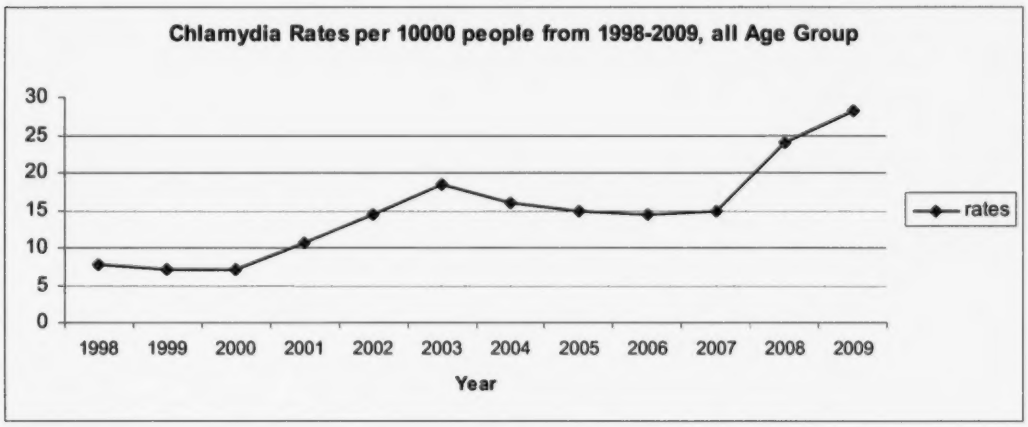
The hepatitis C virus is spread primarily by blood-to-blood contact. In the province, between 1998 and 2000, 70% of the new cases had intravenous drug use (IDU) as a risk factor, whereas in FHHR, at least 37% of those who tested positive for Hepatitis C were intravenous drug users. Risk factors could not be determined for some patients.

A harm reduction program (including a needle exchange program) for injection drug users was established by Public Health in 2002. It includes appropriate immunizations, serological testing, counseling and referrals to addictions, social services, physicians, etc.

HIV: In FHHR for the years 1998 through 2009, there were a total of 12 officially reported cases with an average of just more than 1 case per year (12 cases/11 years).

Chlamydia (a sexually transmitted infection) in 2009: The 15-24 year age group had the highest incident rates of Chlamydia.

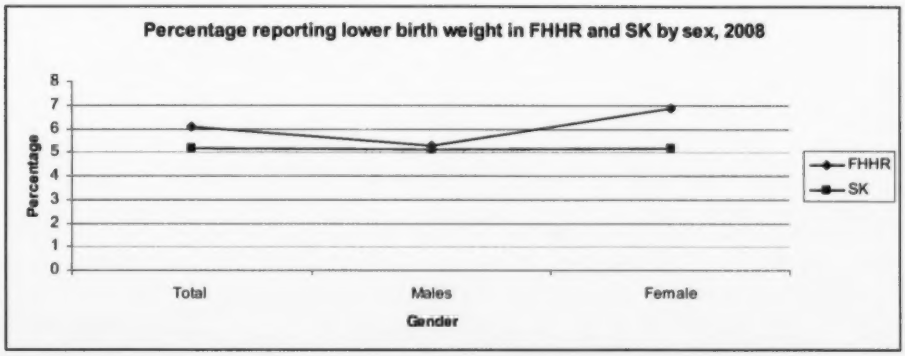




The chlamydia rate has increased since 2008, after being relatively stable for the previous six years. This is due, in part, to increased testing of people who appear to be at risk. (Source: FHHR)

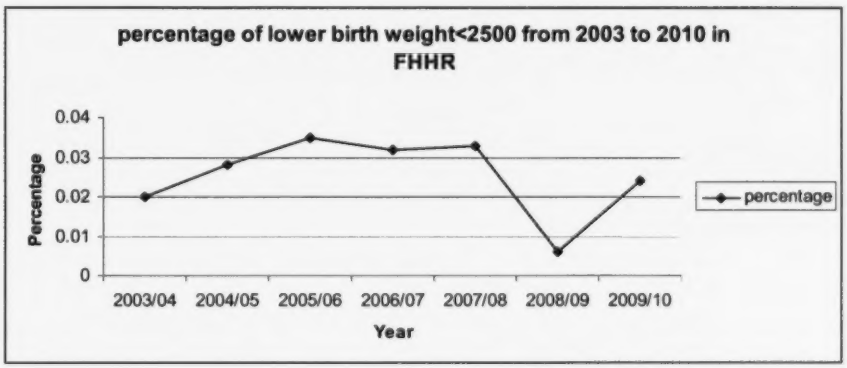
Teen Wellness Clinic in Moose Jaw, run by Public Health Services, was visited by 590 clients in 2009, and complements intervention efforts by Public Health Nurses in the schools.

Low Birth Weight (LBW) infants are infants weighing less than 2,500 grams at birth. LBW can be the result of preterm birth or restricted intrauterine growth. LBW substantially contributes to peri-natal illness and death. It is associated with a higher rate of long-term health problems, including disabilities such as cerebral palsy and learning difficulties.



There was a higher incidence of LBW females in FHHR than in the rest of Saskatchewan in 2008. But for males in FHHR, LBW rates were nearly the same as those in Saskatchewan in 2008. (Source: CCHS)

The chart below shows the number of LBW in FHHR. The rate of female baby LBW was higher than that of male babies from 2007 to 2009. (Source: FHHR)

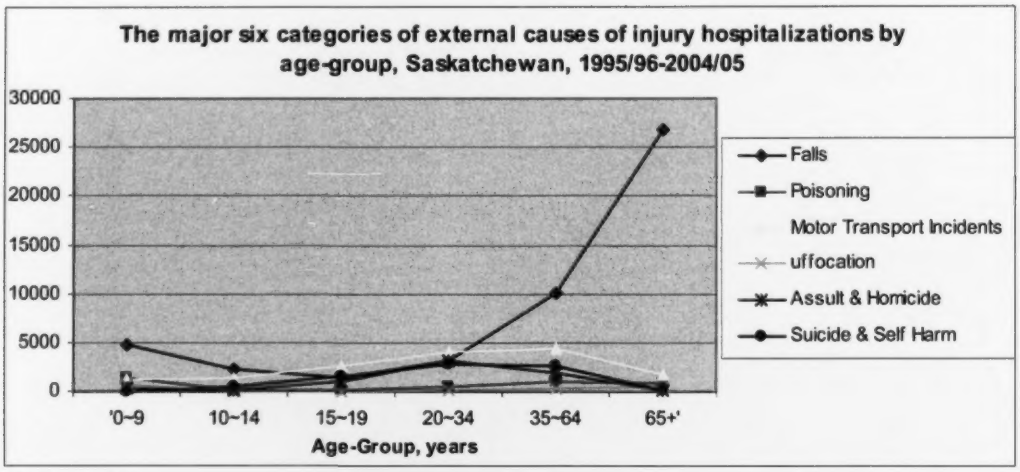


The LBW rate was highest in FHHR in 2005/06 at 0.035% of all live births. 2008/09 had the lowest rate of LBW babies with a 0.006% rate. (Source: FHHR)

Some of the risk factors for lower birth weight are:

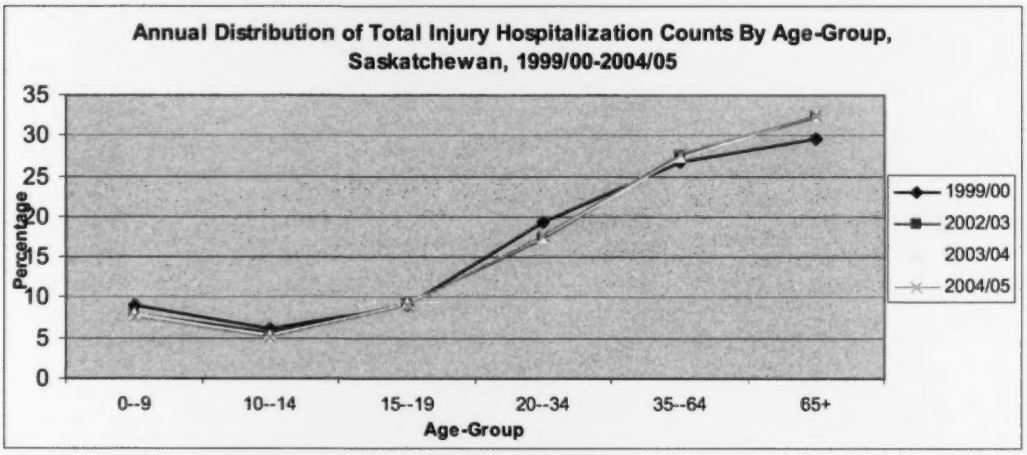
- Carrying more than one baby such as twins or triplets
- Previous lower birth weight babies
- Smoking or exposure to second hand smoke
- Stress and lack of support
- Infection- some infections in pregnant women, such as urinary tract or vaginal infections, can cause labor to start early
- Stressful work conditions such as
    - Long hours
    - Being on your feet for long periods
    - Exposure to harmful substances
- Previous abortions

Injury Hospitalization



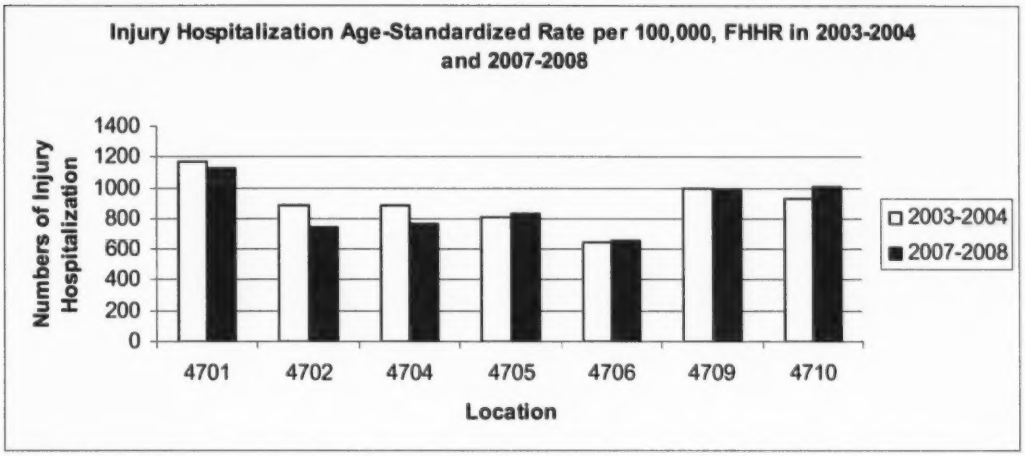
(Source: CIHI)

This figure shows the number of injuries caused by falls increasing with the age.



(Source: Saskatchewan Comprehensive Injury Surveillance, 1995-2005)

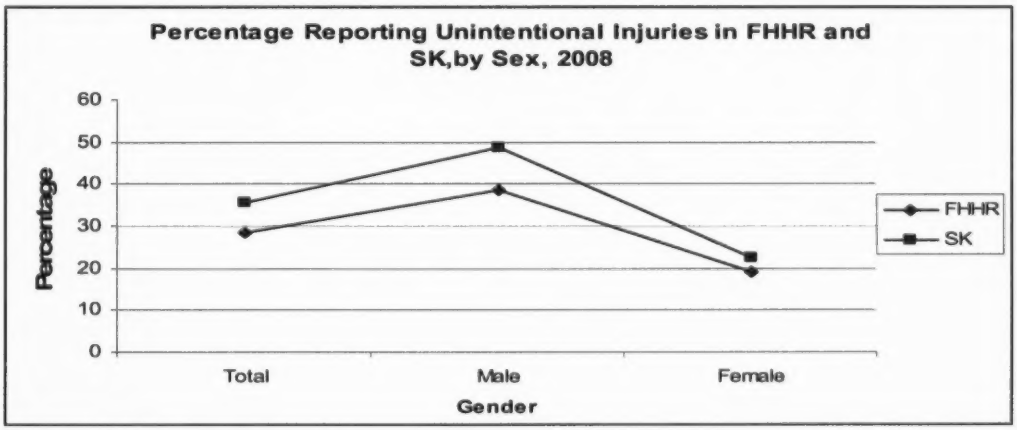
From this figure the percentage of those hospitalized due to injury in 35-64 and 65+ cohorts increased from 1999/00 to 2004/05. For those 65+, it was 29.7% in 1999/00 with an increase to 32.5% in 2004/05. For the age cohorts of 0-9, 10-14, 15-19 and 20-34, the injury hospitalizations decreased from 1999/00 to 2004/05. For the 0-9 age group, it was 9.1 in 1999/00 and decreased to 7.7 in 2004/05.



(Source: Saskatchewan Comprehensive Injury Surveillance, 1995-2005)
4702 = Five Hills Regional Health Authority

This chart shows comparison between health regions in Saskatchewan. There was a reduction in injury hospitalization for FHHR over four years. The 2007-2008 rate is the second lowest in Saskatchewan.

Unintentional Injuries: Injuries have traditionally been defined as injury to a person caused by an acute transfer of energy (mechanical, thermal, electrical, chemical, or radiation) or by the sudden absence of heat or oxygen. Unintentional injuries consist of a subset of injuries for which there is no evidence of predetermined intent.

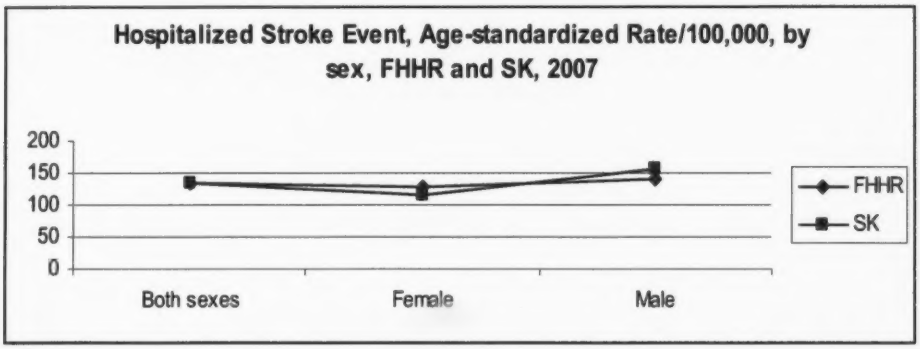


(Source: CCHS)

From this figure, unintentional injuries in FHHR for males and females were all lower than the rest of Saskatchewan in 2008.

Hospitalized Stroke Event: A stroke is the rapidly developing loss of brain function(s) due to disturbance in the blood supply to the brain, caused by a blocked or burst blood vessel. This can be due to ischemia (lack of blood flow) caused by thrombosis or arterial embolism or due to a hemorrhage. As a result, the affected area of the brain is unable to function, leading to inability to move one or more limbs on one side of the body, inability to understand or formulate speech, or inability to see one side of the visual field.

A stroke is a medical emergency and can cause permanent neurological damage, complications, and death. It is the number two cause of death worldwide and may soon become the leading cause of death worldwide.



From this figure, hospitalized stroke event, age-standardized rates/100,000 for both sexes, female and male were similar in 2007 in both FHHR and Saskatchewan. (Source: CIHI)

Human Function

Disability-Free Life Expectancy: Life expectancy is the number of years a person would be expected to live, starting from birth (for life expectancy at birth) or at age 65 (for life expectancy at age 65), on the basis of the mortality statistics for a given observation period. Disability-free life expectancy is a more comprehensive indicator than that of life expectancy because it introduces the concept of quality of life. It is used to distinguish between years of life free of any activity limitation and years experienced with at least one activity limitation.

Disability-Free Life Expectancy (at Birth): Canadians born in 1996 were expected to live free of any disability for 68.6 years (66.9 males, 70.2 females) of their life. For the same year, the average in Saskatchewan was 68.3 years (66.6 males, 70.0 females), and FHHR was at 68.2 years (66.5 males, 69.8 females). Most major urban centers have high disability-free life expectancy at birth as compared to below-average disability-free life expectancy at birth in most of the far north and rural Atlantic Canada. (Source: Statistics Canada)

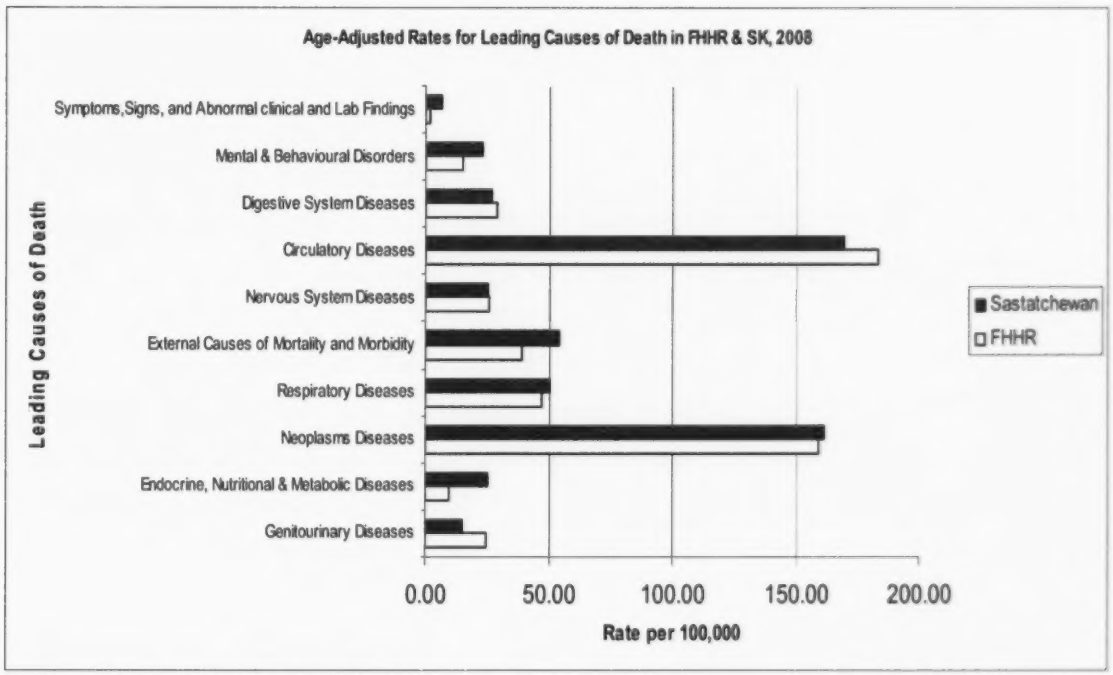
Those born in Saskatchewan in 2008 are expected to live free of any disability for 79 years (76.2 males, 81.8 females) of their life. For the same year, the disability-free life expectancy at birth in FHHR was 78.7 years (75.7 males, 81.6 females).

Disability-Free Life Expectancy (At Age 65): In 1996, Canadians aged 65 years were expected to have another 11.7 disability-free years (10.9 males, 12.4 females) left to live. For the same year, Saskatchewan was 12 years (11.2 males, 12.7 females) and FHHR was 12 years (11.2 males, 12.7 females). Most high-density metropolitan areas have a high disability-free life expectancy at age 65 as compared to below average disability-free life expectancy at age 65 in most of Northern Canada. Disability-free life expectancy in the FHHR area was not significantly different from the national average in the other Health Regions located in the far north and Western Canada (peer group F) which is comprised of Health Regions in Northern Canada, the Prairies, British Columbia and the territories (Source: Statistics Canada)

Health Adjusted Life Expectancy (HALE) is the average number of years that a person can expect to live in full health. It is an indicator of overall population health. HALE is not only a measure of quantity of life but also a measure of quality of life.

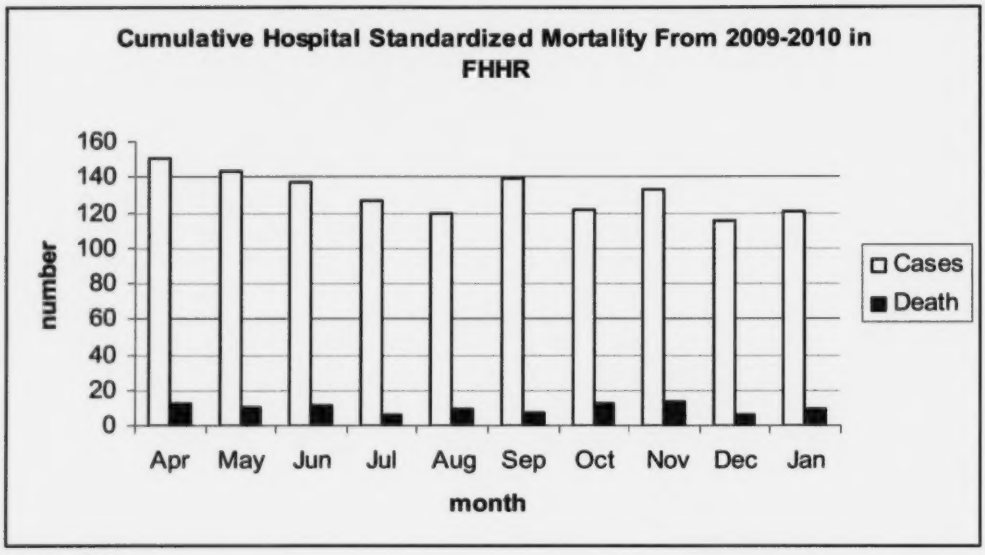
As of 2001, the health-adjusted life expectancy at birth in the highest income category was higher than that of the middle income and lowest income categories. It reflected that quantity of life and quality of life in the highest income group were both higher than that of the middle and lowest incomes. (Source: CCHS)

Deaths



Source: Saskatchewan Health Service Reports

Circulatory system diseases (cardiac disease) and neoplastic diseases (breast, prostate, etc.) were the top causes of death in FHHR and Saskatchewan for 2008. In 2008, external causes of mortality and morbidity (injuries) have surpassed respiratory diseases for Saskatchewan but not in FHHR.



Source: FHHR

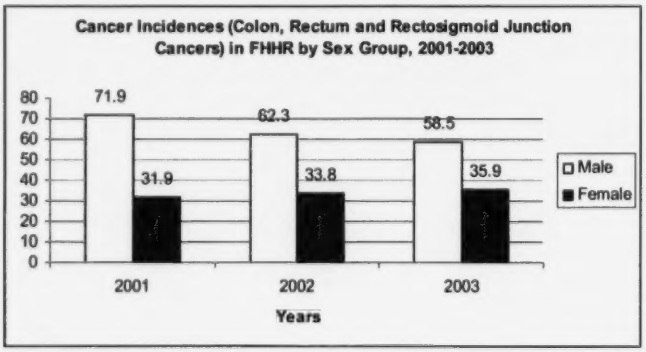
For the cumulative hospital standardized mortality in 2009-2010, the month of April had the highest in cases but October had the highest in deaths in FHHR.

All Cancers: This data is courtesy of Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2000 to 2002. All rates are per 100,000 population.

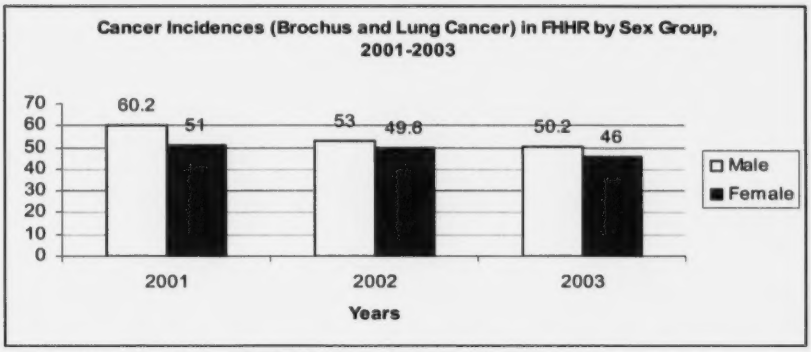
Regional vs. Provincial Cancer Rates

	FHHR (Male)	FHHR (Female)	SK (Male)	SK (Female)
Colorectal Cancer	22.6	11.9	21.3	13.7
Lung Cancer	62.3	40.5	54.8	32.3
Breast Cancer		21.6		23.7
Prostate Cancer	43.9		35.6	

From this table male deaths in FHHR associated with colorectal, lung and prostate cancers, were all higher than those in Saskatchewan. For females, except for lung cancer, cancer rates were lower than that of the province. (Source: CCHS)



On the above chart, male cancer incidences(newly diagnosed cases) (colon, rectum and rectosigmoid junction cancers) decreased from 2001 to 2003 while female cancer incidences (colon, rectum and rectosigmoid junction cancers) increased for the same time period (this table was age-standardized per 100,000 population). (Source: Canadian Cancer Registry)

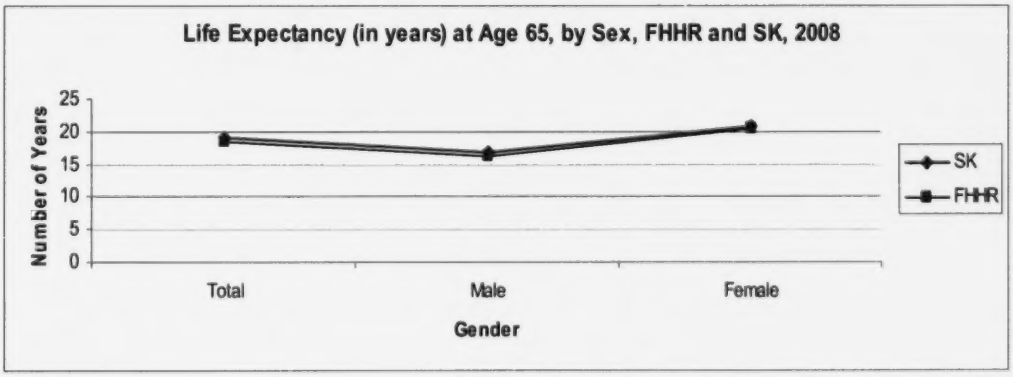


(Source: Canadian Cancer Registry)

On this chart female incidences for bronchus and lung cancers were similar from 2001 to 2003. Male incidences of Bronchus and lung cancers were higher in 2001 (60.2%) than in 2002 and 2003 (this table was age-standardized rate per 100,000 population).

Life Expectancy at Birth: Life expectancy is the number of years a person would be expected to live, starting at birth (for life expectancy at birth) or at age 65 (for life expectancy at age 65) if the age and sex-specific mortality rates for a given observation period (such as a calendar year) were held constant over the estimated life span. Used worldwide, life expectancy at birth is a measure of a population's state of general health. Life expectancy at birth is often compared to health-adjusted life expectancy (HALE) at birth to assess whether the added years of life are spent in good health.

The life expectancy at birth in FHHR and SK were nearly the same in 2008. However, they were all lower than Canadian male and female life expectancy at birth (75.7 and 76.2 vs. 78.69, 81.6 and 81.8 vs 83.91). (Source: CCHS)



(Source: CCHS)

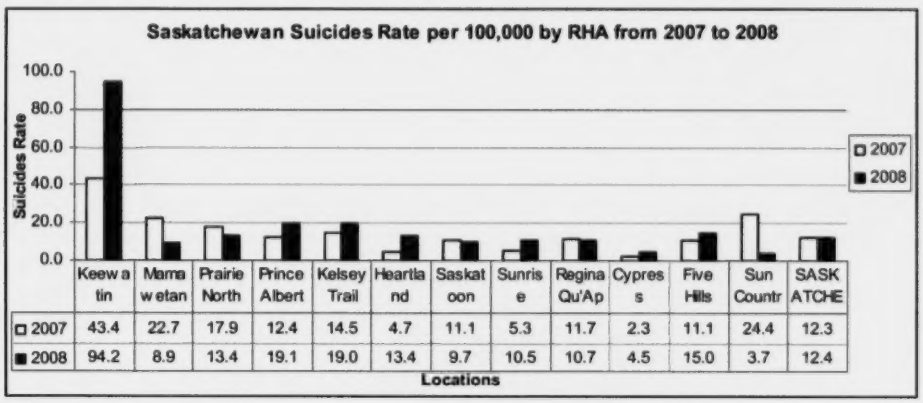
At age 65 in 2008 in FHHR, men could expect to live 16.2 more years on average while women could expect to live 20.6 more years. These numbers were all nearly the same as that of Saskatchewan.

Infant Mortality is defined as the number of infant deaths (one year of age or younger) per 1,000 live births. The most common cause worldwide has traditionally been due to dehydration from diarrhea. Currently the most common cause is pneumonia.

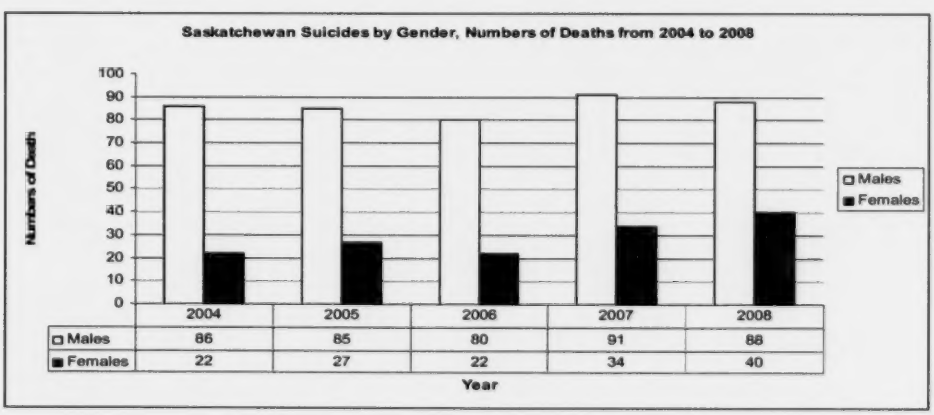
The infant mortality rate for FHHR in 2001-2005 was higher than that in SK. But in 2008, the infant mortality for FHHR decreased sharply, from 7.7 in 2001-2005 to 5.5 in 2008. It was lower than that of SK. (Source: Saskatchewan Ministry of Health)

Suicides by RHA, by Gender and by Age is defined as the intentional killing of oneself. The most common cause is an underlying mental disorder which includes such conditions as depression, bipolar disorder, schizophrenia, alcoholism and drug abuse. Working pressure and financial difficulties or other pressured situations play a significant role.

The first chart illustrates the annual suicide rate (2007 to 2008) for each health region and for the province overall. The second chart illustrates the annual total number of suicides from 2004 to 2008, split by gender. The third chart illustrates the annual number of suicides for each age group, calculated from 2007 to 2008 per 100,000. (Source: Saskatchewan Health Service Reports)

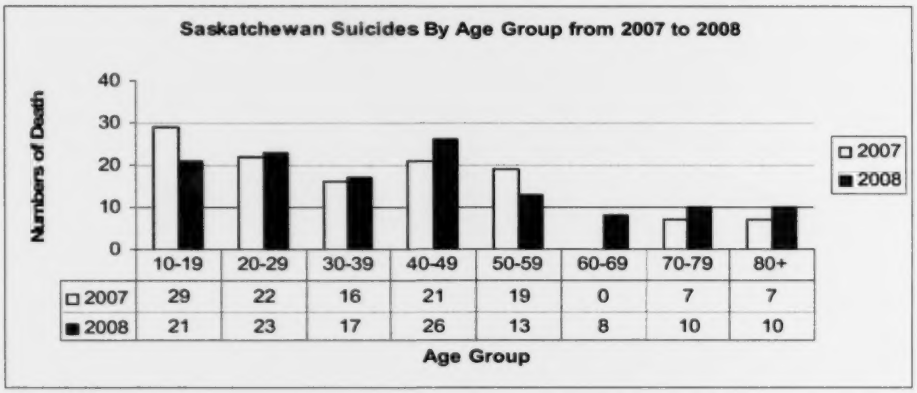


	Keewatin	Mamawetan	Prairie North	Prince Albert	Kelsey Trail	Heartland	Saskatoon	Sunrise	Regina Qu'Ap	Cypress	Five Hills	Sun Countr	SASKATCHE
2007	43.4	22.7	17.9	12.4	14.5	4.7	11.1	5.3	11.7	2.3	11.1	24.4	12.3
2008	94.2	8.9	13.4	19.1	19.0	13.4	9.7	10.5	10.7	4.5	15.0	3.7	12.4



	2004	2005	2006	2007	2008
Males	86	85	80	91	88
Females	22	27	22	34	40

From the chart above, we can see that suicides were more prevalent for males than for females. In 2007, the number of male suicide deaths in Saskatchewan was 91 per 100,000. In 2008, this number was 88 per 100,000. Female rates were less than half those of males with only 34 per 100,000 deaths in 2007 and 40 per 100,000 in 2008. This could be a result of the fact that males are more likely to end their lives through violent means, while women primarily use other methods, such as overdosing on medications.

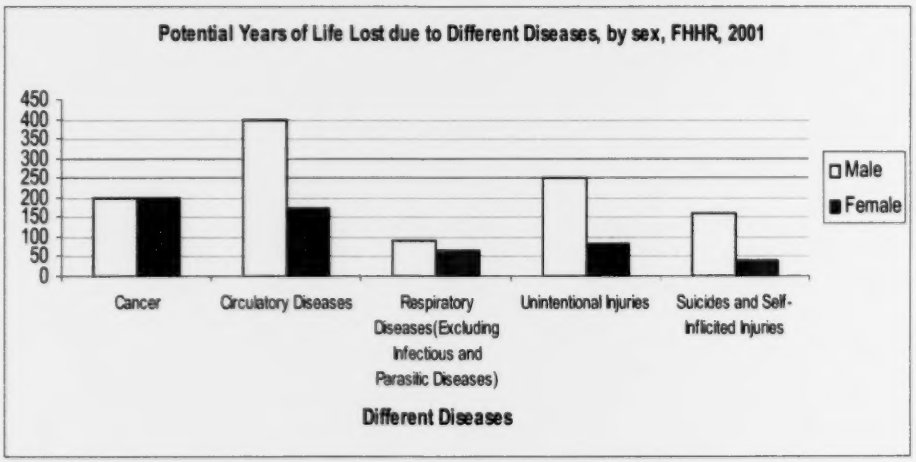


	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+
2007	29	22	16	21	19	0	7	7
2008	21	23	17	26	13	8	10	10

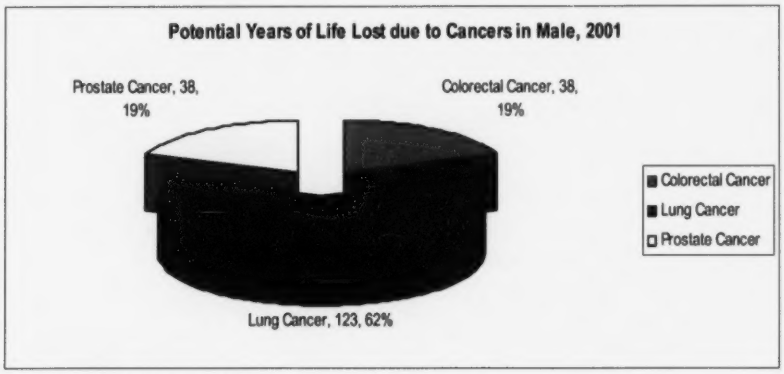
From this chart, the 10-19 year old cohort had the highest number of suicides in 2007 (29 per 100,000), but in 2008, the 40-49 year old cohort had the highest number of suicides (26 per 100,000). The 20-29 year old cohort was the next most affected age cohort (22 in 2007, 23 in 2008 per 100,000).

Potential Years of Life Lost (PYLL): is an estimate of the average years a person would have lived if he or she had not died prematurely. It is, therefore, a measure of premature mortality.

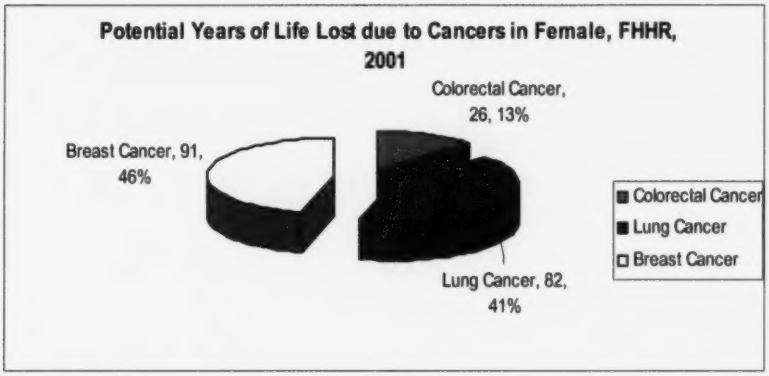
In FHHR in 2001, the total number of potential years of life lost for males was 1838, (all causes) while for females, 1090 years were lost. If we look at the different causes of death, we can find that circulatory disease causes of PYLL were more common in males; but cancers were more common in females. (Source: Statistics Canada)



In the following graphs, the specific type of cancer is followed by the potential years of life lost and the percentage contribution of that specific cancer out of 100%.

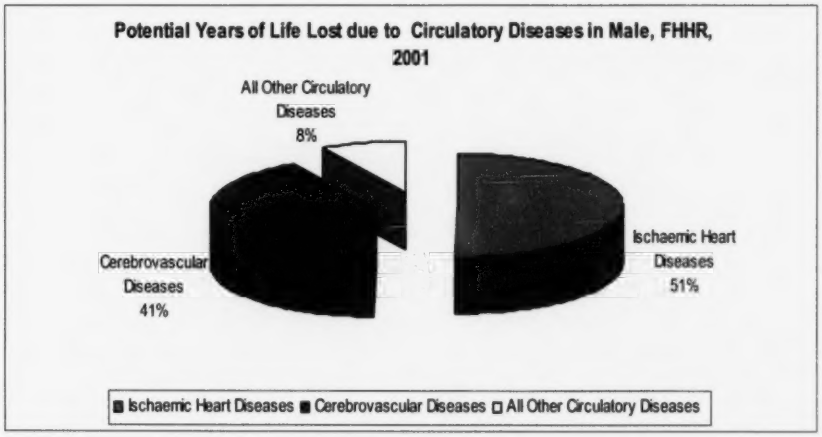

Potential Years of Life Lost due to Cancers in Male, 2001
Prostate Cancer, 38, 19%
Colorectal Cancer, 38, 19%
Lung Cancer, 123, 62%
Colorectal Cancer
Lung Cancer
Prostate Cancer

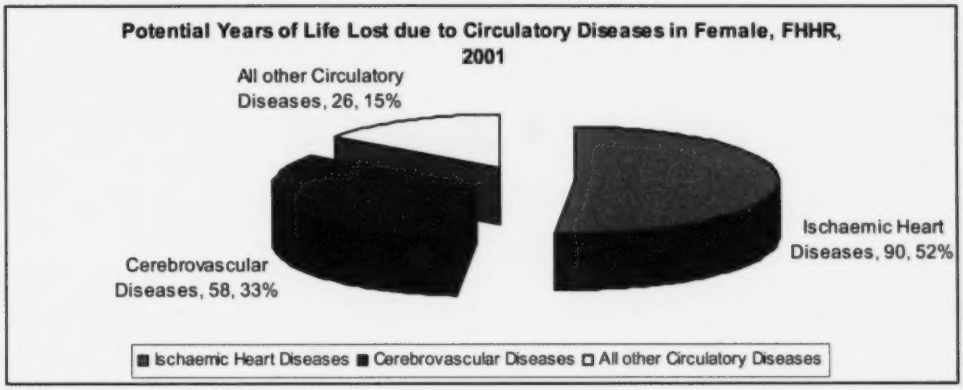
(Source: Statistics Canada)


Potential Years of Life Lost due to Cancers in Female, FHHR, 2001
Colorectal Cancer, 26, 13%
Breast Cancer, 91, 46%
Lung Cancer, 82, 41%
Colorectal Cancer
Lung Cancer
Breast Cancer

(Source: CCHS)

Amongst circulatory diseases in males and femals, ischaemic heart disease (i.e., myocardial infarction) was more common in FHHR in 2001.

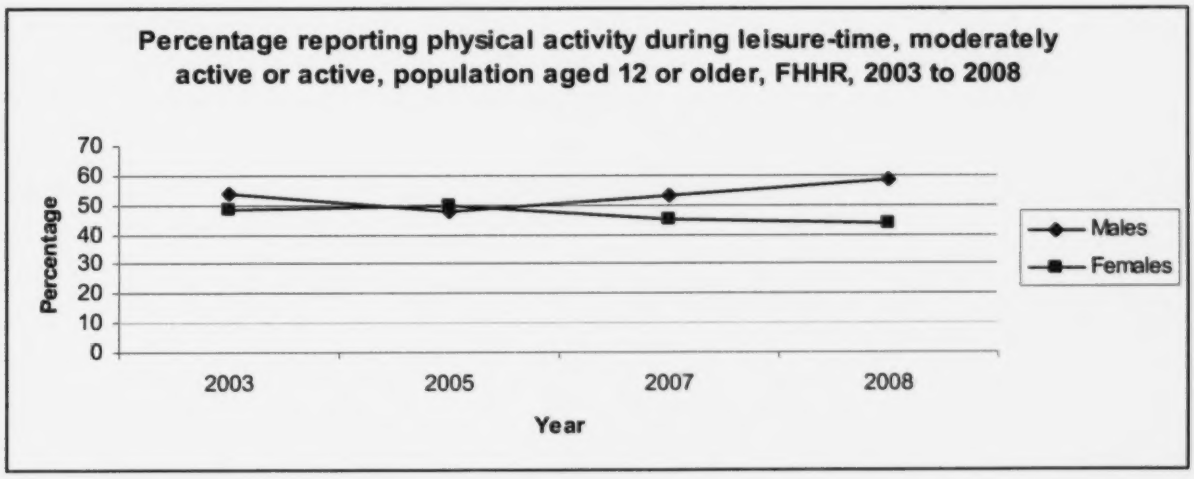

Potential Years of Life Lost due to Circulatory Diseases in Male, FHHR, 2001
All Other Circulatory Diseases 8%
Cerebrovascular Diseases 41%
Ischaemic Heart Diseases 51%
Ischaemic Heart Diseases
Cerebrovascular Diseases
All Other Circulatory Diseases


Potential Years of Life Lost due to Circulatory Diseases in Female, FHHR, 2001
All other Circulatory Diseases, 26, 15%
Cerebrovascular Diseases, 58, 33%
Ischaemic Heart Diseases, 90, 52%
Ischaemic Heart Diseases
Cerebrovascular Diseases
All other Circulatory Diseases

B. Non-Medical Determinants of Health

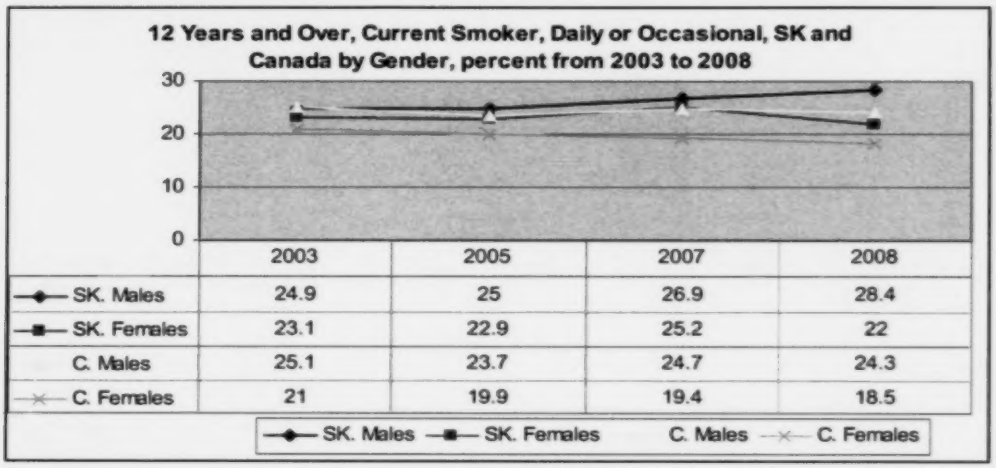
Health Behaviors

Physical Activity During Leisure Time: The following figure showing physical activity during leisure time in the moderately active or active population in FHHR shows us that males and females were almost the same from 2003 to 2005. In 2006, males participated in more physical activity during leisure time than females with a rate of 58.8% while the rate among females was only 44% in 2008 (CCHS).



Smoking is a risk factor for lung cancer, heart disease, stroke, chronic respiratory diseases, and other conditions. Smoking is a significant and preventable cause of death.

In 2008, 164,200 Saskatchewan residents were smokers, 20.4% of the population. This rate was above the 17.9% rate for Canadians as a whole but was a reduction from Saskatchewan's 2007 rate of 24.0%. (Source: Canadian Tobacco Monitoring Survey (CTUMS), 2009)

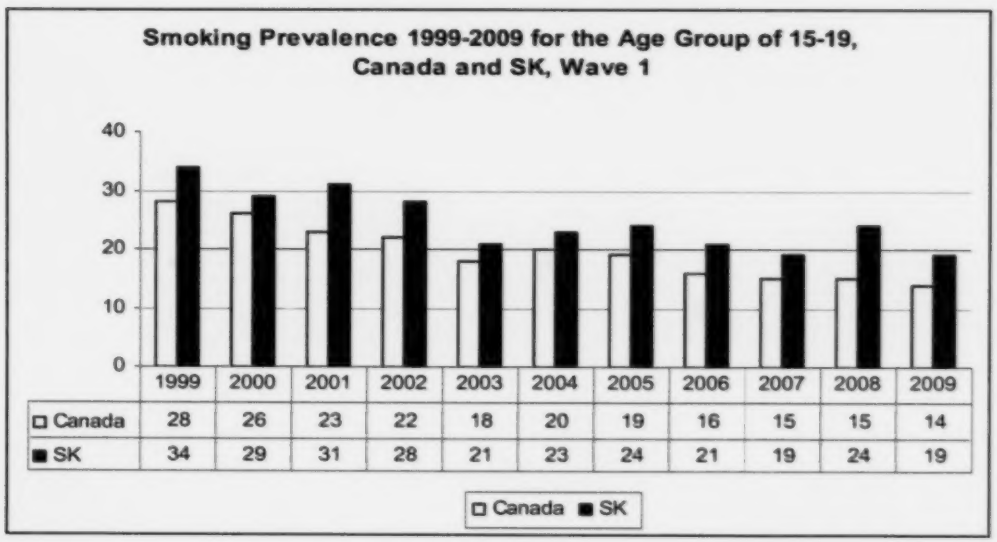

12 Years and Over, Current Smoker, Daily or Occasional, SK and Canada by Gender, percent from 2003 to 2008
30
20
10
0
SK. Males SK. Females C. Males C. Females

	2003	2005	2007	2008
SK. Males	24.9	25	26.9	28.4
SK. Females	23.1	22.9	25.2	22
C. Males	25.1	23.7	24.7	24.3
C. Females	21	19.9	19.4	18.5

The figure above shows that the percentage of Saskatchewan females who smoked was higher than that of females nationally. The percentage of Saskatchewan males was higher than that of males nationally, except in 2003. (Source: CCHS)

There is a demonstrated upward trend in smoking in females and males after a drop in 2005 in FHHR.

Tobacco Use among Canadian Youth



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Canada	28	26	23	22	18	20	19	16	15	15	14
SK	34	29	31	28	21	23	24	21	19	24	19

"Wave 1" refers to the first wave of information gathering. The prevalence rates of smoking in Saskatchewan for the age group of 15-19 were higher than those of Canada from 1999 to 2009. The trend for Saskatchewan flattened out at 19% of 15-19 year olds, with an outlying figure of 24% in 2008. The smoking rate among youth aged 15-19 years was 14% in 2009in Canada, unchanged from the same period last year.
(Source: Canadian Tobacco Monitoring Survey (CTUMS), 2009)

Based on 2009 (February-June), the current smoking rate among Saskatchewan youth aged 15-19 years was 19%. A higher percentage of Canadian male teenagers (16%) were current smokers compared to Canadian female teenagers (12%).

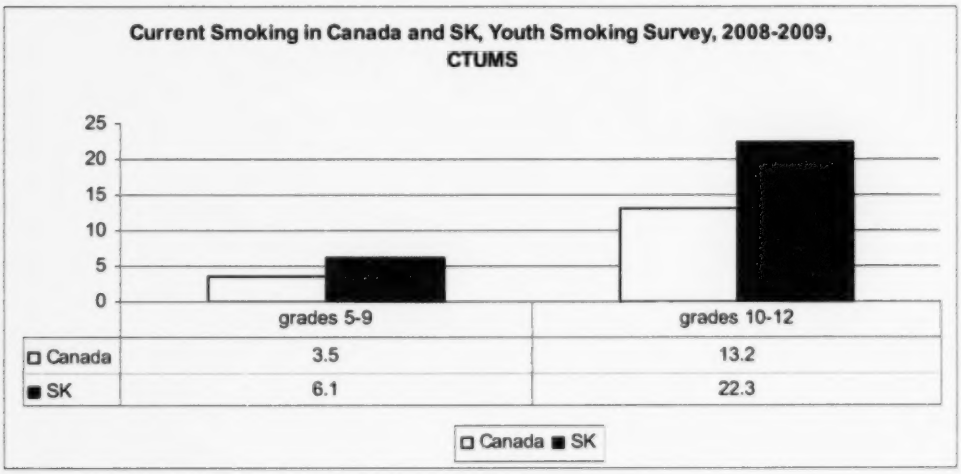
In FHHR for the population aged 12-19, the overall smoker numbers decreased from 24.1% in 2003 to 22.3% in 2005. Female smokers also decreased from 26.3% in 2003 to 19.5% in 2005 while male smokers increased from 21.9% in 2003 to 25.1% in 2005.
(Source: Canadian Tobacco Monitoring Survey (CTUMS), 2009)

In 2006-2007:

- 2.4% of Canadian students in Grades 5-9 (11-14 years old) were current smokers. In Saskatchewan, 2.2% of students this age were current smokers.
- For Grades 10-12 (15-19 years old), 14.8% of Canadian youth were current smokers, but 16.9% of youth in Saskatchewan were.

In 2008-2009:

- 3.5% of Canadian students in Grades 5-9 (11-14 years old) were current smokers while in Saskatchewan, 6.1% of students in this age group were smokers.
- 13.2% of Canadian youth Grades 10-12 (15-19 years old) were current smokers. But in Saskatchewan, this figure was 22.3%.



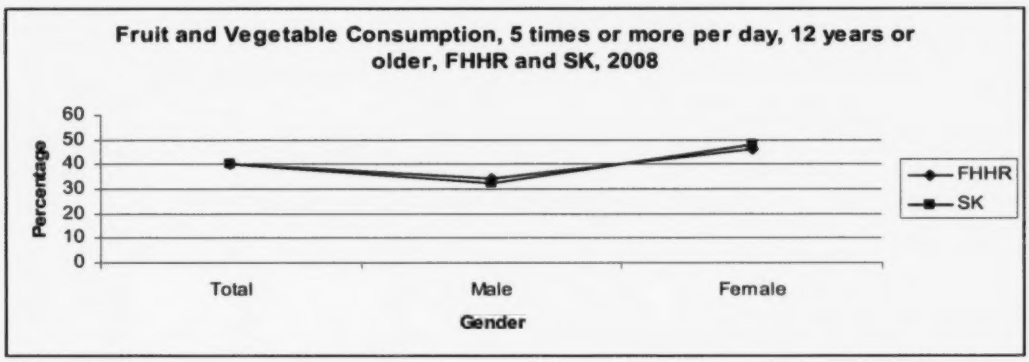
(Source: Canadian Tobacco Monitoring Survey (CTUMS), 2009)

Drinking (heavy) refers to having consumed five or more drinks per occasion, at least 12 times a year. This level of alcohol consumption can have serious health and social consequences, especially driving while intoxicated.

In FHHR, the number of males consuming 5 or more drinks on one occasion, at least once a month in the past year, were far greater than the number of females doing so from 2003 to 2008. The 2008 percentages for the health region are almost identical to the provincial results. (Source: CHHS)

Fruit and Vegetables Consumed at Least 5 Times Daily:

This following figure shows females usually consumed fruits and vegetables at least 5 times daily more often than males in 2008. It was 46.2% for females (48.3% for SK) and 34.5% for males in FHHR (32.2% for SK). (The data for specific age-cohorts re: consumed fruit and vegetables at five times daily in FHHR, is not currently available.) (Source: CHHS)



Food Security: Access to enough safe, affordable food is an important determinant of health. Food security impacts physical health, learning and mental well-being (*The Cost of Healthy Eating in Saskatchewan, 2006*). Food security and poverty are also important indicators of infant birth weight, child health and child development (*HungerCount 2009*). In 2007, Health Canada estimated that almost half of people in the lowest income category experienced food insecurity. The most vulnerable group as regards food insecurity is children under age 2 due to its consequences on growth, health and development. The cost of housing and rental units has also dramatically increased recently in Saskatchewan. "When costs increase for other basic needs, such as housing, transportation and child care, there is less money available to spend on food." *

Children of food-insecure households experience poorer overall health and an increased risk of being hospitalized. Chronic conditions such as cardiovascular disease, type 2 diabetes, and hypertension are also related to food insecurity.

Good prenatal and infant nutrition are key for optimal growth and development. Children who have access to good food experience improved academic and social functioning. They demonstrate better attendance, attention and behaviour when they are not hungry (*The Cost of Healthy Eating in Saskatchewan, 2006*).

Food insecurity can result from a number of factors including income, environment and social factors. Collaboration and efforts from all sectors of society are required to reduce food insecurity and its effects.

On average, it costs a reference family of four persons (2 adults, 2 children) $205.02 per week to eat a nutritious diet in Saskatchewan. Large cities have the lowest food costs ($184.91 per week) compared to rural areas which are the most expensive ($204.94 per week). Costs are higher in northern Saskatchewan.

**The Cost of Healthy Eating in Saskatchewan 2009: Impact on Food Security. Executive Summary. Public Health Nutritionists of Saskatchewan Working Group. April 2010.*

Breastfeeding: From the CCHS survey, 16% (2003) and 32% (2005) of FHHR mothers exclusively breastfed for at least 6 months (20% (2003) and 23% (2005) for SK). According to the 2007/2008 CCHS survey, 87.5% of SK mothers initiated breastfeeding, while 90.9% of FHHR mothers initiated breastfeeding. In Saskatchewan for the same time period, 32.5% of mothers exclusively breastfed their babies for at least 6 months, compared to the Canadian average of 25.9%.

The FHHR Public Health Service's survey (2007/2008) showed us that initiation of breastfeeding was 93.65%of mothers with new babies. The breastfeeding rate at 2 months was 83.07%. The breastfeeding rate at 6 months was 50.26%.

	Initiated Breastfeeding	2 Months	4 Months	6 Months	12 Months	more than 12 months
Numbers	177	157	115	95	63	24
Percentage	93.65%	83.07%	60.85%	50.26%	33.33%	12.7%

The survey also indicated a correlation between education level and the duration of breastfeeding. The higher the mother's education level was, the longer they breastfed their babies. For example, of those mothers who had breastfed for 12 months:

- 3 (4.76%) had less than high school education;
- 25 (39.68%) had a four-year university program education.

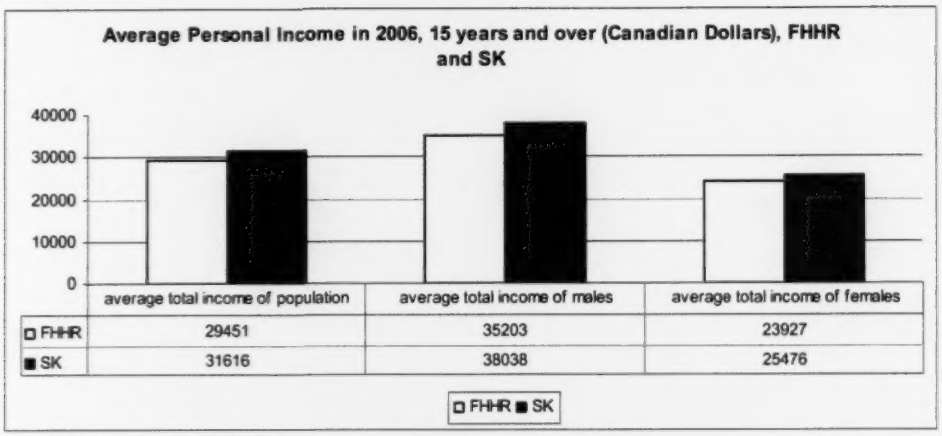
Breastfeeding initiation and maintenance rates increase with increasing education levels. This suggests that there are many social factors that influence the mode of infant feeding (Health Canada, 1996).

Living and Working Conditions

Children in Low Income Families

In 2008, the percentage of children in low income families in FHHR was lower than in Saskatchewan. (Source: CCHS)

Average Personal Income



From this figure the average personal income in FHHR was lower than that in Saskatchewan in 2006 for males and females. The median household income (number) for FHHR was $43,888, which was lower than that in Saskatchewan ($46,705).

Personal Resources

Life Satisfaction is a measure of an individual's perceived level of well-being and happiness. Life satisfaction can be assessed specific to a particular domain of life (e.g., work, family) or globally. In 2008, females in the health region reported high levels of life satisfaction, while men reported slightly lower levels. (Source: CCHS)

Sense of Community Belonging is "the perception of similarity to others, an acknowledged interdependence with others, a willingness to maintain this interdependence by giving to or doing for others what one expects from them, and the feeling that one is part of a larger dependable and stable structure".

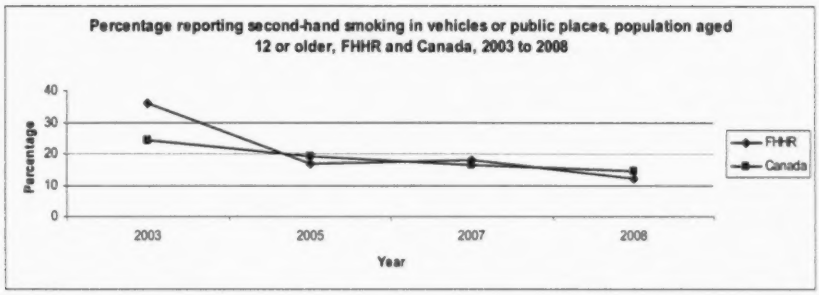
The sense of belonging to local community in females was strong or very strong, and usually higher than that of males in FHHR from 2003 to 2008.

Environmental Factors

Second-Hand Smoking at Home

Second-hand smoking at home in FHHR had been increasing since 2005 and was greater than that of Canada starting in 2007. Exposure to second-hand smoking at home in Canada has been steadily decreasing since 2003.

Second-Hand Smoking in Vehicles or Public Places



Rates of second-hand smoking in vehicles or public places in FHHR and Canada have been nearly the same since 2005. (Source: CCHS)

C. Health System Performance

Accessibility

Immunization Rates: As per Canadian National standard, the coverage rate is the specific rate of immunization coverage, by a child's second birthday. This is an important milestone, as a child should have received the primary immunization series by this time.

Immunization records as of August 30, 2009 show that a higher percentage of infants in FHHR had been vaccinated by their second birthday than the provincial average. The rate of immunization by that age is an important indicator of protection from communicable diseases and is measured in jurisdictions across Canada and reported as the immunization coverage rate.

	SIMS Population	Diphtheria (4)	Pneumo-7(4)	Varicella (1)	Meningococc (1)	Haemophilus Influenzae Type B (4)	Measles (2)	Mumps (2)	Pertussis	Polio	Rubella (2)	Tetanus (4)
Five Hills	548	85.2	80.7	91.1	91.2	83.8	82.8	82.8	85.2	85	82.8	85.2
Saskatchewan	11903	79.2	77.3	89.3	89.7	77.9	79.4	79.3	79.1	79.1	79.3	79.2

Seasonal Influenza Immunization Rates for Seniors (65 years of age and older): This is a cost-effective population health measure, reducing both morbidity and mortality due to respiratory causes in this vulnerable age-group.

This information in the table below indicates that FHHR has steadily increased its percentage of those covered by the 'flu' shot, over the last three reporting periods:

FHHR Year	% Adults 65+ Immunized	SK Year	% Adults 65+ Immunized
2004/2005	68%	2004/2005	68%
2005/2006	67%	2005/2006	66%
2006/2007	63.30%	2006/2007	63.40%
2007/2008	63.60%	2007/2008	62%
2008/2009	64.90%	2008/2009	Not Yet Available

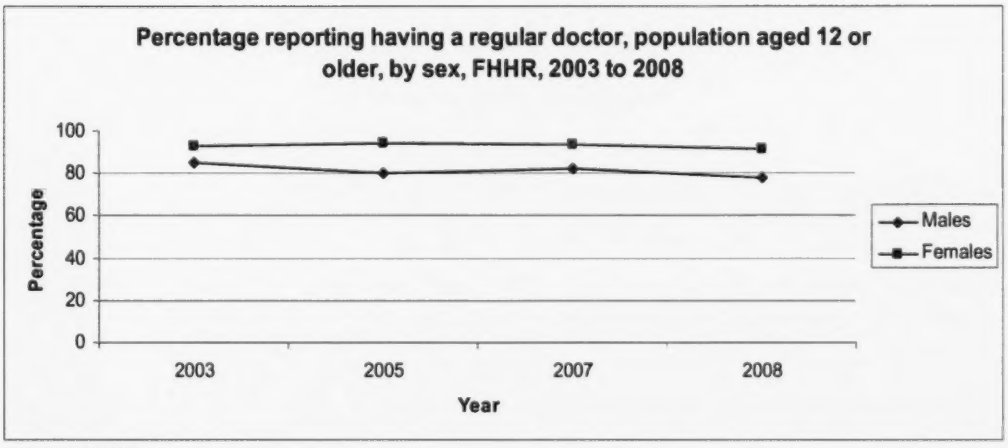
(Source: Ministry of Health)

P-H1N1 Influenza Immunization Coverage Rates as at 8th January, 2010:

	<5	5--9	10--19	20--34	35--64	65+	Total
FHHR %	63	65	42	26	41	57	43
SK %	63	69	47	31	43	56	46

(Source: Ministry of Health)

Regular Medical Doctor



(Source: CCHS)

This figure shows the percentage of females having a regular medical doctor in FHHR was higher than that of males and higher than that of Canada females from 2003 to 2008 (91.8% vs. 88.3%, 2008).

Mammograms are probably the most important tool doctors have not only to screen for breast cancer, but also to diagnose, evaluate, and follow up people who have had breast cancer. Safe and reasonably accurate, a mammogram is an x-ray photochart of the breast. The technique has been in use for about 40 years. Screening mammograms are typically done every year to check the breasts for any early signs of breast cancer.

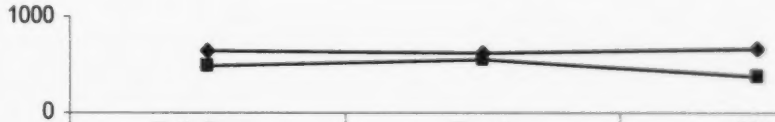
In 2008, the percentage of females 50 to 59 years old receiving a mammogram within the last 2 years was lower than females 50 to 59 years old in 2005. But the 2008 percentage of females 60 to 69 years old was higher than the 2005 rate. (Source: CCHS)

Pap Smear is a simple test for the early detection of dysplasias and cancers of the cervix. Pap smear testing saves lives, with statistics showing if women had regular pap tests, 90% of cancer of the cervix would be prevented. In 2005, the total number of 18 to 69 years olds having pap smear test in FHHR was 16,753. The percentage of these women having had at least one pap smear in FHHR in 2008 was 73.9% which was lower than the provincial level (77.1%).
(Source: CCHS)

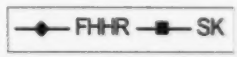
Safety

Hospitalized Hip Fracture Event Rate: A broken hip is a common injury, especially in elderly individuals. Hip fractures are generally associated with the highest morbidity, mortality and burden on healthcare resources, given that patients may require multidisciplinary care, long periods of convalescence and long-term social care following discharge from hospital.

Hospitalized Hip Fracture Event, Age-standardized rate/100,000 by sex, FHHR and SK, 2007



	Both Sexes	Female	Male
FHHR	648	619	664
SK	484	557	370

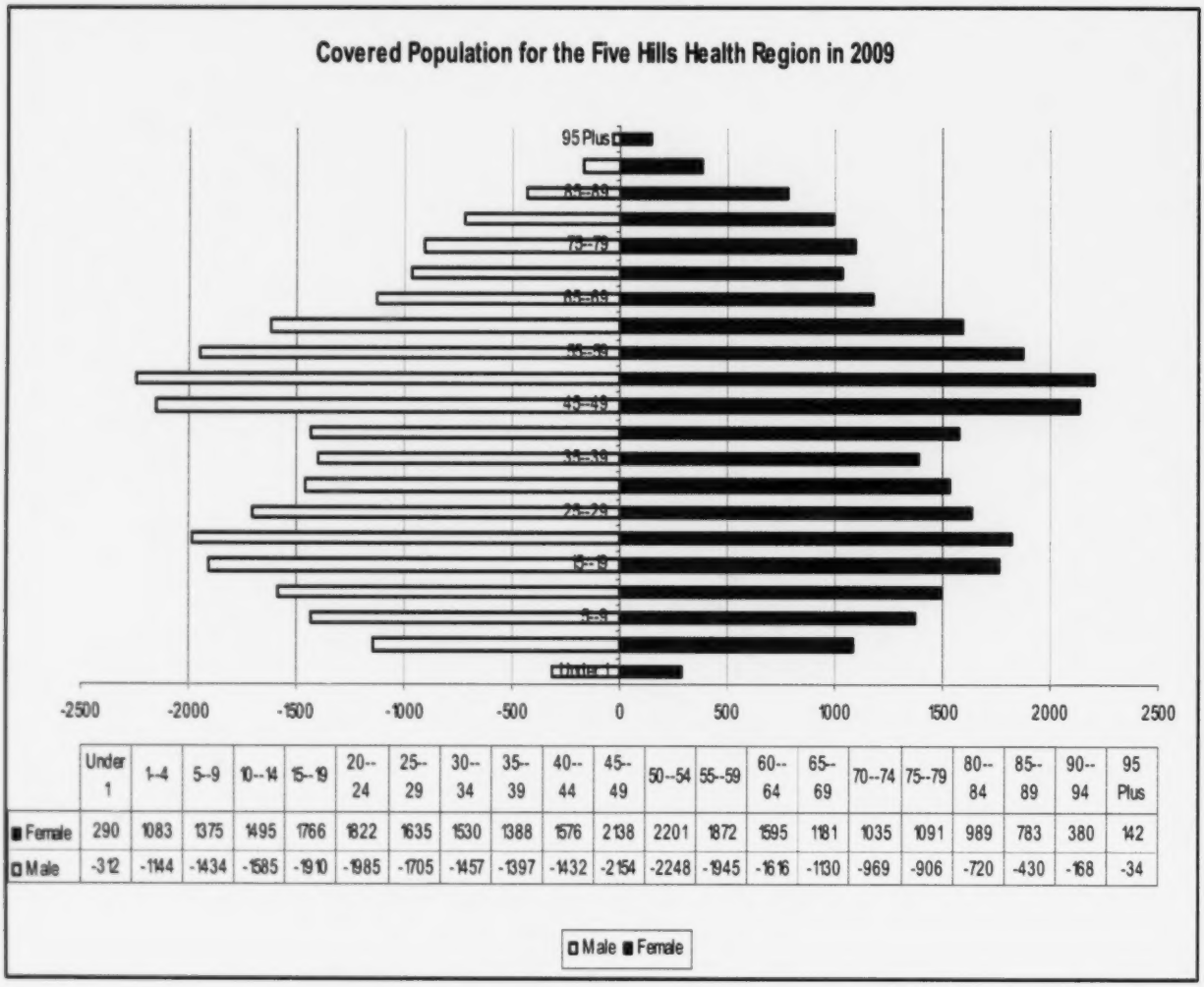


From this figure, the hospitalized hip fracture event, age-standardized rate/100,000 for male and female in FHHR were all higher than that in Saskatchewan as a whole. (Source: CCHS)

D. Community and Health System Characteristics

Community

Population Estimates



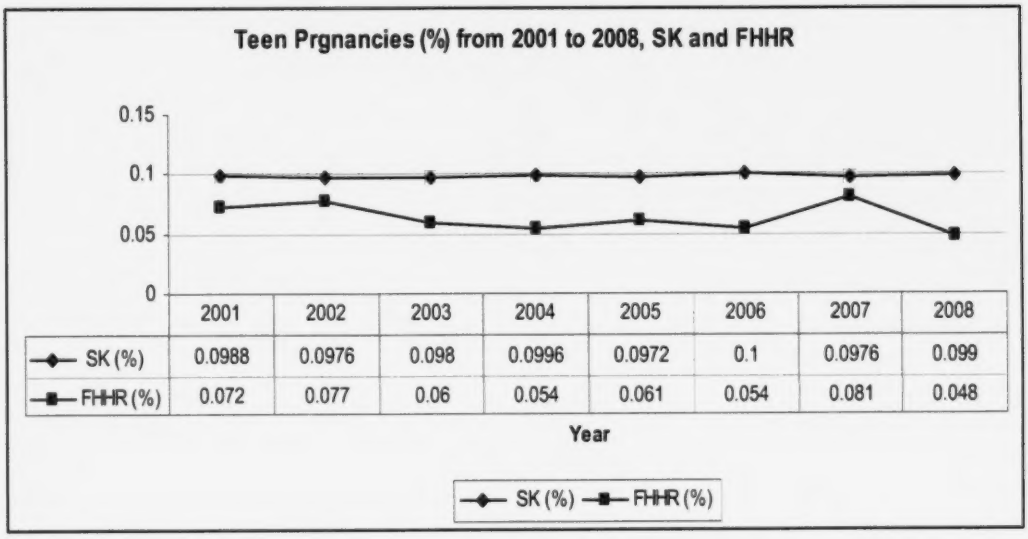
	Under 1	1--4	5--9	10--14	15--19	20--24	25--29	30--34	35--39	40--44	45--49	50--54	55--59	60--64	65--69	70--74	75--79	80--84	85--89	90--94	95 Plus
Female	290	1083	1375	1495	1766	1822	1635	1530	1388	1576	2138	2201	1872	1595	1181	1035	1091	989	783	380	142
Male	-312	-1144	-1434	-1585	-1910	-1985	-1705	-1457	-1397	-1432	-2154	-2248	-1945	-1616	-1130	-969	-906	-720	-430	-168	-34

In 2009, there were 54,046 (26,680 males, 27,366 females) people with health services coverage living in FHHR. (Source: Ministry of Health)

There were 2,210 (1,115 males, 1,095 females) people aged 25 to 29 who graduated from high school; 10,920 (4,950 males and 5,970 females) people aged 25-54 who graduated from post-secondary school). 715 (355 males, 350 females) people were long-term unemployed and 7,350 (3,260 males, 4,090 females) people lived on low incomes. (Source: Census 2008)

Teen Pregnancy (15-19 years)

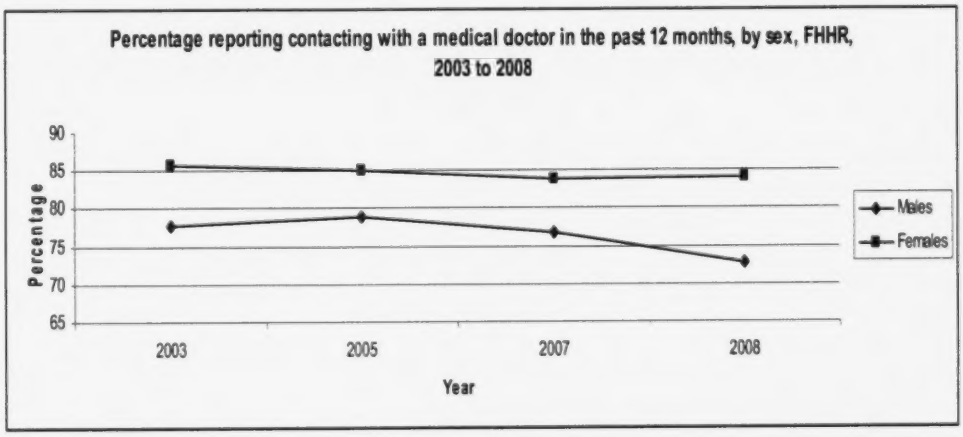
The first chart illustrates teen (15-19 years old) pregnancies as a percentage of all pregnancies in the FHHR and in Saskatchewan from 2001 to 2008.
(Sources: Five Hill Health Region and Saskatchewan Health Service Utilization Reports)



	2001	2002	2003	2004	2005	2006	2007	2008
SK (%)	0.0988	0.0976	0.098	0.0996	0.0972	0.1	0.0976	0.099
FHHR (%)	0.072	0.077	0.06	0.054	0.061	0.054	0.081	0.048

The teen pregnancy rate of the FHHR has always been lower than that of Saskatchewan. There was noticeable increase in the FHHR teen pregnancy rate in 2007.
(Source: Saskatchewan Health Service Utilization Report)

Health System



This figure shows females had a higher percentage of contact with a medical doctor in the past 12 months than males in 2008 in FHHR. These numbers were very close to the provincial average. (Source: CCHS)

Emerging Public Health Issues

1. Viral and Bacterial Diseases

1.1 Planning for Future Influenza Pandemics

The South (and recently the North) Saskatchewan Pandemic Forum, is a practical forum for the exchange of ideas regarding pandemic influenza planning. Provincial groupings of MHOs, acute care directors and public health, proved to be invaluable in operationalizing the pandemic response in 2009. The Shared-Services Forum can continue the useful strategies used in the Pandemic.

1.2. Arbovirusses

Arbovirus is defined as a class of virus transmitted to humans by arthropods such as mosquitoes and ticks.

West Nile Virus (WNV) is now well established in Saskatchewan, and FHHR. WNV is a cyclical disease, reflecting a spill-over of the disease from its cycle in nature, to humans. As in 2003 (223 cases), 2007 (116 cases) proved to be a high incidence year for FHHR. The 2007 figure translates into a rate of 215 infections/100,000 people. The overall provincial rate for 2007 was 134/100,000. 2008 was a low-incidence year for both FHHR and the Province, as exhibited in the following table:

Total # of WNV Cases

Year	FHHR	SK Total
2003	225	947
2004	2	5
2005	6	60
2006	1	20
2007	113	1456
2008	2	17
2009	0	1

*Total cases comprises both West Nile Neurological Syndrome, PLUS West Nile Non-Neurological syndrome PLUS the Asymptomatic cases.

This disease is dependent on the culex tarsalis mosquito, and mosquito proliferation in turn is heat-dependent. Global warming will influence these and other diseases, giving rise to the term transmerging diseases, i.e. the emergence or re-emergence of infectious diseases, new and old, against the background of a transforming weather and economic environment. A good example is dengue fever, rapidly spreading across South America and the Caribbean. Surveillance will also detect new mosquitos in our region allowing us to be on the lookout for accompanying diseases such as Saint Louis Encephalitis, should they move north.

Larviciding is a mainstay of the WNV control programme. It is important for municipalities to be able to larvacide in heavy years to reduce health risks. The biggest impacts are likely to be felt in the larger urban areas especially those in the south of the province, including Moose Jaw and

Estevan, for example. The Provincial WNV Coordinator has stressed the importance of larviciding as an important component of the WNV control strategy. It is difficult to predict how heavy a WNV season one will have, as it is largely weather driven and is directly proportional to the number of accumulated heat-units (degree growing days) for that specific summer season. On the other hand, we have had two seasons of low WNV activity in Saskatchewan. Other preventive measures include the use of personal protective measures, which everyone should be following at the appropriate time. Adulticiding (spraying adult mosquitoes) is a last-ditch tool, i.e. used sparingly hitherto only in cases of significant break-through WNV activity.

1.3 **Antibiotic Resistant Organisms (ARO's)** continue to present a challenge, requiring continually changing approaches to stay ahead of organisms such as MRSA (Methicillin-Resistant Staph Aureus) and CDAD (Clostridium Difficile Associated Disease)(sometimes referred to as C. Difficile), amongst others.

Methicillin Resistant Staphylococcus Aureus (MRSA)

	2001	2002	2003	2004	2005	2006	2007	2008	2009
# of new cases	3	18	21	76	101	86	116	130	125

Methicillin Resistant Staphylococcus Aureus (MRSA)
Community Associated vs. Healthcare Associated 2009

Type	# cases
HAI	15
Community Associated	110
Total	125

Benchmark Rate - Clinical Isolates 5.89/10000 pt days (CNISP Western Regional Data 2007)
Baseline Data- Screening Isolates 6.07/10000 Patient Days (MJUH Data 2008)

HAI MRSA Rate per 10,000 Patient Days at MJUH (Year to Date)			
	Total # of cases	Screening Isolates	Clinical Isolates
2008	28	6.07	3.37
2009	7	3.87	2.9

The southern portion of the Province, including FHHR, is affected predominantly by the health-care associated (HAI) types of MRSA. As one travels northwards in Saskatchewan, the proportion of community-associated MRSA types, increases.

Some staphylococci are becoming resistant even to the fluoroquinolone group of antibiotics. To interrupt transmission of these and evolving resistant organisms, we need to:

- know about the latest mechanisms of how this resistance is conferred, i.e. by plasmids and integrons;

- realize that the old standbys of hand hygiene and barrier isolation precautions, remain critically important; and
- educate clinicians and the public of the need to only use antibiotics when necessary.

Accreditation standards now include producing evidence of an appropriate hand-washing, with evidence of adherence to the required high standard, by all occupational groupings within Health Care.

Clostridium Difficile Associated Disease (CDAD)

	2005	2006	2007	2008	2009
# of new cases	27	20	26	27	37

Clostridium Difficile Associated Disease (CDAD)
Community Associated vs. Healthcare Associated 2009

Type	# cases
HAI	13
Regional	24
Total	37

1.4 Health-Facility-Associated Outbreaks (Respiratory and Enteric)

This includes both enteric and respiratory outbreaks, in both long term care facilities (LTCs), and acute care facilities, within the FHHR. Outbreak response requires considerable teamwork, and resources, to effectively combat the often complex outbreaks. Outbreak protocols require constant updating – a work-in-progress. The staff component within affected facilities is often stretched to the limit during outbreaks, especially over weekends. Complexities can include multiple simultaneous outbreak etiologies (organisms) within a single facility.
Enteric outbreaks are commonly caused by the Norovirus group.

Respiratory outbreaks are commonly caused by Parainfluenza or influenza viruses. H1N1 Human Swine Flu can potentially cause an outbreak in any facility housing people in the long-term.

The table below depicts the main outbreak categories in facilities, to date:

Year	Enteric Outbreaks	Respiratory Outbreaks	Total Outbreaks
2006	10	2	12
2007	11	5	16
2008	15	14	29
2009	10	22	32

2. Special Interest Groups

Immigrants, refugees and other special interest groups need considerable assistance in order to settle successfully in our country. Access to health services is included in this process, and we need to continually strive to facilitate this process. This includes the necessary supports to facilitate the transition to the health services of a developed country such as ours. Language and cultural barriers present real obstacles to success.

Ongoing close cooperation with multicultural centres is essential. Planning has enabled public health nurses to begin screening multicultural centre immigrants (as of May 2007 from a primary health care (PHC) perspective, and to liaise with specific physicians. Public Health Services interaction with the Regional Intersectoral Committee has, in May of 2009, culminated in the creation of a Health Educator position, to be housed at the Moose Jaw Multicultural Centre. In February 2010, the acute-care needs of this immigrant/refugee cohort have been addressed by the Primary Health Care Team initiative in Moose Jaw. A dedicated RN-Nurse Practitioner as part of a PHC-team, which includes Public Health Services, assesses and provides for the primary health care needs of this population. This helps ensure an integrated and comprehensive team provision of primary health-care services.

3. Teen Sexual Health

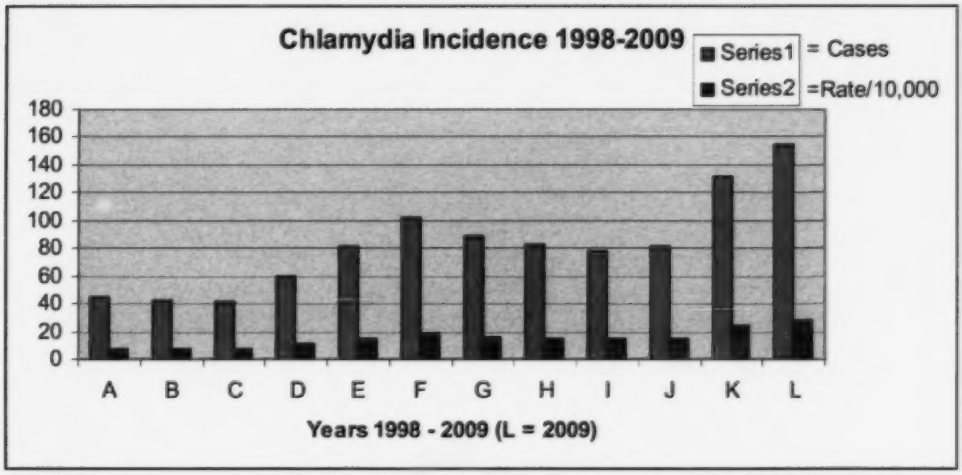
In 2008 two surveys were conducted by the Teen Wellness Clinic. The Teen Wellness Client Survey, from August 2008 to January 2009, was designed to assess satisfaction with services, accessibility and knowledge of the Clinic. The final report is pending but one of the highlights was that overall the clients are very satisfied with our services and Mondays remain the day of choice. The second was administered to Grade 9 and 10 students in the Prairie South School Division. The Teen Awareness Survey was designed to assess the student's knowledge of the TWC, birth control methods and where they received sexual health information. The final report is pending. An informal time survey was conducted for 6 months to learn when our clients attended our clinic. The majority of clients attended between 3 and 6 pm. Therefore it was decided to change clinic hours to 2 to 6pm to better serve TWC clients.

MHO Dr. Mark Vooght, and Dr. Brad Thorpe, provide medical coverage to the TWC. Teen Wellness Clinic Public Health Nurses have begun education and training in order to perform Pap Testing.

One of the important preventions stressed at the TWC, is the prevention of sexually transmitted infections. One of these is Chlamydia, which is on the increase provincially and in the FHHR. Chlamydia rates have increased since 2008, after being relatively stable for the previous six years. The 15-24 year age group has high incident rates of Chlamydia. The Teen Wellness Clinic in Moose Jaw, run by Public Health Services, was visited by 590 clients in 2009, and complements intervention efforts by Public Health Nurses in the schools.

Chlamydia Cases: FHHR		
Year	Cases Total	Rates per 10,000
1998	45	7.7
1999	42	7.2
2000	41	7.2
2001	60	10.6
2002	82	14.5
2003	102	18.5
2004	89	16.0
2005	83	15.0
2006	78	14.5
2007	81	15.0
2008	131	24.0
2009	154	28.2

(Rate of cases per 10,000 persons)



Age Group	2009 Male and Female Cases	2009 Total Population Cohort	2009 Rate per 10 000
<1			
1-4			
5-9			
10-14	3	3,202	9.4
15-19	44	3,868	113.8
20-24	64	3,978	160.9
25-29	21	3,370	62.3
30-39	20	5,790	34.5
40-59	2	15,867	1.3
60+			
Unknown			
TOTALS	**154**	**54,674**	**28.2**

5. Injection Drug Use and Harm Reduction

A harm reduction program (including a needle exchange program) for injection drug users was established by Public Health Services in 2002. It includes appropriate immunizations, serological testing, counseling and referrals to Mental Health and Addictions, social services, physicians, etc. It has reached at-risk individuals to the extent that 43,110 needles, together with appropriate harm-reducing safety items including tourniquets, spoons, sterile water, pellet filters, and approved sharps (needle) containers, were dispensed in 2009.

The Needle Exchange Program Survey of 2008, was supportive of the work done in Saskatchewan, but emphasized that more work needed to be done in ensuring needle-free public spaces, and that the harm reduction programs strive to be evidence-based and utilize the latest harm-reduction modalities, and to share this information amongst themselves.

The newly released (May 2010) SK HIV Strategy foundations document, emphasizes the pillars of HIV prevention, control, and treatment. It emphasizes a team-approach to client service (i.e. a team that is inclusive of a range of healthcare disciplines including PHC practitioners). The newly formed SPHC will be assisting in the direction of this new strategic approach.

7. Early Childhood Development

Since the 1990s our understanding of early childhood brain development has increased significantly. We have learned that the structures supporting social, emotional and mental development occur in early childhood and that the capacity to build these foundations is greatest in the early years. We have also learned that early stimulation is required for optimal brain development while "toxic" stress through child abuse, neglect or family violence can damage these evolving brain structures. With this understanding, an important initiative called the "understanding early years" or UEY has been undertaken throughout all kindergarten classes in our health region. Through a standardized instrument, kindergarten teachers' have assessed children on a number of important domains critical in early learning. The results from this survey will allow us how to see how our young children compare to other children throughout Canada. Not only will we have a better understanding of the developmental needs and challenges of young children in our health region, but this information will provide a baseline measure against which the successes of future initiatives may be measured! Between our new understandings and the work that has already started, early childhood development can be implemented with more focus than in the past.

8. Dental Health: Dental Screening Program

Since 1993, dental health screenings have been provided to children by the dental health educators of the FHHR. The purpose of this screening, conducted every 5 years, is to assess the oral health needs and to identify children with unmet dental needs and to allow referral of obvious dental treatment. In 2008 – 2009, Grade One and Grade Seven students were screened. In Grade One, tooth decay remains a significant childhood problem. This can be equally said for children in Grade Seven with tooth decay of the permanent teeth.

In Grade One, 47.5% of students were cavity-free and the percentage of unmet dental needs was 27.8%. These findings do not meet the Canadian Oral Health Strategy guidelines (2010) for Grade One. The guidelines state that 50% of children should not have experienced dental decay, and no more than 20% of children have unmet dental treatment needs.

In Grade Seven, 80.7% of students have never experienced decay in their permanent teeth; unmet dental needs were 9.3%. The Canadian Oral Health Strategy guidelines have been met for this age group.

Of the 34 Elementary schools in the FHHR, 17 schools (50%) had 20% or more of their Grade One and Grade Seven students, with visible decay present. These schools are designated as being at high risk for dental need. Ten schools (29.4%) had 10% or more, but less than 20% of their Grade One and Grade Seven students with visible decay. These schools are designated as having medium risk for dental need. Seven schools (20.6%) had less than 10% of their Grade One and Grade Seven students with visible decay.

In 2008 – 2009, 62.7% of children attending a school in an urban community were cavity free compared to 47.6% of children attending a school in a rural community. 60.6% of children attending schools with community water fluoridation were cavity free compared to 47.7% of children attending schools without community water fluoridation.

Overall, the percentage of children with cavities has increased since the first screening report conducted in 1993 – 1994. Risk factors for dental decay have been indentified over the years including poor oral hygiene practices, diets high in sugar, and poor bottle-feeding practices. This report re-emphasizes the importance of community water fluoridation, good oral hygiene programs, daily flossing, fluoride mouth-rinse programs, and early detection of oral disease.

9. Pertussis in Saskatchewan and FHHR

There has been an increase in pertussis (whooping cough) cases in Saskatchewan over the last three years, especially in infants under the age of one year. There have been five deaths in infants from pertussis in Saskatchewan during this three-year interval.

FHHR last experienced pertussis cases (2) in 2006; however 2002 was a heavy year for Pertussis cases (154 in that year alone). Fortunately, the introduction of the new acellular Pertussis vaccine, including that given to Grade 8 students, has resulted in a drop-off of cases, with no cases being detected in the last 3 years in FHHR.

Public Health in Saskatchewan/Five Hills Health Region is working with communities to ensure children are up to date with their routine childhood vaccination program. This includes pertussis vaccine given at 2, 4 and 6 months with a booster at 18 months and 4 years. In communities where outbreaks of pertussis occur, mothers of infants are also being offered the pertussis vaccine in the form of Tdap (Adacel or Boostrix), where pertussis is a component of the routine adult tetanus booster. Health care providers who care for infants and pregnant women should also consider receiving a Tdap booster. The FHHR provides this free for their staff when they present for their 10-yearly Td booster (in the form of Tdap).

In addition to being up to date with vaccination, prompt diagnosis and treatment of pertussis in infants is important to prevent hospitalization and death. Pertussis is most serious in younger infants because although vaccination begins at 2 months, their immune response to the pertussis component of the vaccine is sub-optimal until mid infancy. All five pertussis-related deaths in Saskatchewan occurred in infants under the age of three months.

2009-2010 Performance Results

Pursing Excellence in Five Hills Health Region

Pursuing Excellence is a quality improvement initiative that looks at health care from the customer's/patient's perspective and what is of value to them. Using that focus, health service processes are reviewed to determine if there are areas where gains can be made by doing things more efficiently and effectively. These areas are reviewed by staff and physicians working in the area and ideas for improvement are initiated for small scale improvements. The improvements are tracked to determine what effect they made on the service to the customer.

The Region has changed process in over 45 different areas and currently has 40 projects underway with four major strategic project areas of focus - Releasing Time to Care (RTC), Medication Reconciliation, Discharge Planning and WCB and Attendance Management.

Releasing Time to Care (RTC)

The RTC program has become a significant part of the Pursuing Excellence Program that was started on the Medicine Unit as the concept site for RTC within the Moose Jaw Union Hospital and the Mental Health and Addictions Inpatient unit was the context test site for RTC. The Region has started the initial planning process to bring RTC to Surgery and Women's Health as part of the Phase 1 of the provincial rollout of RTC.

The RTC program consists of three foundational modules and nine process modules. This program is designed to increased the direct care provided to patients but also provides for the opportunity to develop standards and efficiencies through the process.

Primary Health Care Teams

All PHC teams are participating in the Health Quality Council (HQC) Collaborative on depression and/or chronic obstructive pulmonary disease (COPD). Quality improvement work is underway to evaluate group sessions for people living with depression and adaptation of a pulmonary rehabilitation program to be delivered in a rural setting. Chronic Disease Management services are provided from the Patient Education Centre with work ongoing to improve efficiencies in the delivery of services to better meet customer needs at both urban and rural locations, in order to provide seamless care as close to home as possible.

PHC teams are working on Clinical Practice Redesign in order to better understand their supply and demand and to improve office flow to achieve improved access for customers.

PHC has developed working relationships with many community leaders and community members with a desire to obtain feedback and develop community programs that are meaningful to the community.

The establishment of the Moose Jaw PHC team has enabled the region to address concerns related to the unmet health needs of the newcomer population with a refugee background arriving in Moose Jaw. The nurse practitioner sees newcomers shortly after their arrival to determine their health needs and care for them directly or refer them to the appropriate healthcare provider.

Mental Health and Addictions

Associated with the standard mental health and addictions services are some innovative programs such as **Kids First**, (an integrated school team), the **Family Outreach Program** and many other intersectoral initiatives. New money from Health Canada's Drug Treatment Funding Program has allowed the Region to create appropriate and accessible treatment and recovery programs for youth aged 12 to 24 years. The program is community based and evidence informed. Funding provided by Health Canada is 1.8 million dollars over four years.

Pursuing Excellence initiatives utilizing Lean productivity improvement tools have provided Mental Health and Addictions Services the opportunity to improve access to services and decrease wait times.

Intensive Care Unit

In February 2010, the Intensive Care Unit saw the successful completion of a $2 million renovation and upgrade at the Moose Jaw Union Hospital. The renovations provide more privacy and dignity for patients who are now better protected against the spread of infection. Included is a new post-operative recovery area for patients requiring constant monitoring following surgery, a new medication area, and a new dedicated physician area which provides access to mobile imaging technology.

The total project budget was $2.1 million and the costs did not exceed the budget. The Ministry of Health provided $650,000 in infrastructure funding. The Moose Jaw Health Foundation matched the $650,000 with gifts from donors. The Board authorized $800,000 from capital funds. The Moose Jaw Health Foundation donated an additional $322,000 for new equipment.

PACS

PACS (Picture Archiving and Communication System) was implemented in November 2009 at Moose Jaw Union Hospital. PACS modernizes and improves the efficiency of Diagnostic Imaging (DI) services in our major centres.

PACS will:

- improve patient care
- improve the referral and scheduling of patients
- streamline reading of exams
- promote faster and more informed patient-care decisions
- reduce treatment delays

Patients will experience:

- fewer unnecessary repeat exams
- reduced wait times for exams
- access services closer to home
- reduced costs due to savings on film processing and handling

This project addresses recommendations in the Patient First Review. It is a vital element in the government's strategy to modernize diagnostic services and improve the delivery of care to residents all across Saskatchewan. PACS is a part of the provincial electronic health record.

Strategic and Operational Directions for Five Hills Health Region 2009-2010 (Based on 2009-10 Accountability Document)

1.0 HEALTH OF THE INDIVIDUAL			
Goal 1.1	**The health system and its employees / providers are focused on providing exceptional care and service to its customers that is consistent with both best practice and customer expectations.**		
Strategy	**1.1.2 To improve both understanding of the patient's experience and the transparency of the health system by routinely and consistently measuring, reporting, analyzing, establishing and meeting / exceeding expectations respecting the quality of services delivered across the continuum of care**		
Key Action 1.1.2.1: To develop, implement and publicly release by December 31, 2009, a Board approved plan for engaging the customer that includes clear service delivery expectations and region-specific targets for improved customer engagement and satisfaction Customer Service Engagement Training Plans for new staff – January 30, 2010	**Measures:** • % of RHA staff who have received orientation on the RHA's service delivery expectations by March 31, 2010 • % of patients who rate service as excellent or exceptional	**Target**: • Submit customer engagement training plans for new staff (January 31, 2010) • 100% of new staff receive orientation on an ongoing basis (in place by March 31, 2010) • 100% of existing RHA staff have received orientation on the region's service delivery expectations by March 31, 2011	**Analysis of Progress:** The Region's customer service training program, Voice of the Customer, was implemented on January 15, 2010. As of March 31, 2010, 12.24% of employees had received training. The training is on target to have 100% of staff trained by March 31, 2011.
Key Action 1.1.2.2 To jointly (Regional Health Authorities and Ministry of Health) develop an action plan in response to the recommendations contained in the Patient First Review that is supported by the Ministry and the RHAs	**Measures:** • Status of Ministry and RHA plan as of December 31, 2009	**Target:** • Plans are complete, including required consultations, and actionable by December 31, 2009; associated resource requirements have been identified for purposes of 2010-11 budget development	**Analysis of Progress:** No report at this time – awaiting further direction from the Ministry.

Goal 1.2	**People have timely access to evidence-based and quality health services and supports**		
Strategy	**1.2.1 To develop and implement a strategy to better manage surgical waitlists and improve access to care**		
Key Action 1.2.1.1: To improve the appropriateness, efficiency and effectiveness of processes involved in the delivery of diagnostic imaging and surgery by:	**Measures:** • % of SSCN approved care pathways implemented as of March 31, 2010	**Target**: • Implementation of 100% of the SSCN approved care pathways for Hip and Knee, Spine and Prostate by March 31, 2010	**Analysis of Progress:** Hip and Knee Pathway fully implemented April 2009.
(a) increasing the use of evidence-based care through the use of care pathways, practice guidelines and other decision support tools;	• % of Diagnostic Imaging Network (DIN) approved diagnostic imaging decision support tool implemented as of March 31, 2011.	• Tool being piloted in Five Hills and Regina Qu'Appelle health regions in 2009-10. • Participate with the ministry in the evaluation of the decision support tool following the pilot project.	Five Hills Health Region participated in pilot of Diagnostic Imaging Network (DIN) decision support tool in 2009-2010. Advised by the Ministry that any further work on project is pending.
(b) implementing Shared Decision Making methods and approaches to inform and engage patients in decisions about elective surgery; and	• Status of implementing Shared Decision Making for the following surgical procedures as of March 31, 2010: Hip and knee, spine and prostate	• Full implementation by March 31, 2010	Shared Decision Making for hip and knee underway in Five Hills Health Region. Ministry investigating if tools of researchers are available for pilot testing. Customers are being sought out to be part of pilot project committee.
(c) building capacity within Regional Health Authorities with respect to the use of improvement science methodologies specifically oriented to improving flow, efficiency, patient and provided satisfaction (for example, advanced access, queuing theory, Lean, operations research)			

...cont...

Goal 1.2 People have timely access to evidence-based and quality health services and supports

Strategy	1.2.1 To develop and implement a strategy to better manage surgical waitlists and improve access to care		
Key Action 1.2.1.2 To adopt, monitor and achieve the targets established by the Ministry for diagnostic imaging and surgery, and to improve both patient flow and the patient experience across the entirety of the surgical episode value stream, from primary care through to rehabilitation and home	**Measures:** • Surgical volumes compared to target • # and % of patients waiting 12+ months for surgery • CT scan - # and % of exams and elective patients served within 90 days compared to targets	**Target:** • 100% of expected surgical case volumes, as follows: Five Hills – 3,940 cases • 100% of expected hip and knee replacement surgical volumes, as follows: Five Hills – 110 cases • 0% of patients wait 12+ months for surgery • 100% of expected patient volumes for CT scans, as follows: FH – 4,450 exams	**Analysis of Progress:** 2009-2010 – 4051 surgical cases performed 2010-2011 – 611 cases performed to the end of May 2011 2009-2010 hip and knee volumes – 86 cases were performed – target was not met due to orthopaedic availability and because of clinical decisions not to perform surgeries 2010-2011hip and knee volumes – target is 100 cases to be performed – 13 cases have been performed to end of May 2011. 10 patients are on waiting list. There is presently a 3-week waiting period. Some patients are choosing to wait longer (i.e., after harvest). 0 patients waiting 12+ months for surgery. 2009-2010 – 5,112 exams performed 2010-2011 – 507 exams performed to end of May 2011
Key Action 1.2.1.3 To develop and implement, by June 30, 2009, a Board approved plan for discontinuing the placement of patients in need of long-term care in an acute care bed for any duration of time	**Measures:** • # of patients classified as awaiting long-term care placement in an acute care bed by facility and by region as of June 30, 2009 and March 31, 2010	**Targets:** • The number of patients classified as awaiting long-term care placement in an acute care bed has been reduced by 65% as of March 31, 2010	**Analysis of Progress:** Target achieved

Goal 1.3 The system works to continuously improve health care safety			
Strategy	**1.3.1 To identify priorities for improving patient and provider safety, establish performance targets and reporting expectations, and accountability for results**		
Key Action 1.3.1.1 To develop and implement a Board approved plan for ensuring the region is in compliance with the CSA (Canadian Standards Association) and accreditation standards for infection control	**Measures:** • Compliance with Accreditation Canada (formerly known as the Canadian Council on Health Services Accreditation) required organizational practices for infection control, including hand washing and equipment sterilization	**Target**: • 100% compliance by March 31, 2010	**Analysis of Progress:** Hand Hygiene Required Organizational Practice (ROP) Status – In 2009, Five Hills Health Region Infection Control initiated surveillance program to monitor indicator. Baseline statistics indicating current state have been collected and will be followed with staff education sessions in Fall 2010. Follow-up surveillance will be conducted at the end of 2010. Changes to program will be considered at that time and an ongoing, sustainable Hand Hygiene Surveillance and Education program will be finalized. Sterile Processing ROP Status – Significant progress made towards standardization of regional policies and procedures in this area. Centralized Sterile Processing has been centralized in Moose Jaw from community hospitals and health centres. Work ongoing to have podiatry sterilization centralized within the next 2 months.

2.0 PROVIDERS			
Goal 2.1 Health service providers have a personal commitment and ownership in creating and working in a caring and high performance environment			
Strategy	**2.1.2 To demonstrate system-wide improved performance through the adoption of quality improvement methods and approaches**		
Key Action 2.1.2.1 To achieve more effective and productive use of health system resources by: (a) building a culture that embraces learning and continuous improvement; (b) building the capacity for the system-wide adoption of a culture of "Lean", a patient-centred approach that focuses on creating more value for customers by eliminating activities that are considered waste; and (c) achieving, within three years and with the support of the Health Quality Council, the adoption and implementation of *Releasing Time to Care* (RTC) in every ward in every regional and tertiary hospital	**Measures:** • # of wards in regional and provincial hospitals that have adopted and implemented Releasing Time to Care • Status of adoption of other products in the Productive series (for example, the Productive OR Theatre, Productive Community Services)	**Target:** Board approved target 2 Units Implemented: - Medicine - Mental Health Inpatient Board approved target (dependent, in part, on the availability of the Productive series through the Health Quality Council)	**Analysis of Progress:** 100% of target achieved Releasing Time to Care has been implemented on two units with another two units preparing for implementation. Requested Community Health Productive Program through Health Quality Council – not available at this time.

Goal 2.3 The health sector has a highly skilled, professional and diverse workforce with a sufficient number and mix of service providers			
Strategy	**2.3.1 To establish the health sector as a workplace that is effective at retaining and recruiting workers**		
Key Action 2.3.1.1 To establish partnerships with First Nations and Métis communities and organizations to effectively attract, recruit, retain and promote First Nations and Métis employment and participation in the region	**Measures:** • To develop a Board approved strategy and targets for increasing First Nations and Métis representation in the region's workforce	**Target:** • Board approved strategy and targets by October 1, 2009	**Analysis of Progress:** Target not yet achieved. Declaration not mandatory. A resurvey will be completed to improve accuracy of statistics in relation to First Nations and Metis representation. Future Representative Workforce initiatives will be developed on this basis.
Key Action 2.3.1.2 To reduce absenteeism through improvements to workplace safety, and improvements in time management and staff scheduling processes	**Measures:** • % reduction in overtime • % reduction in WCB time lost claims / days lost • % reduction in employee sick time	**Target:** • 5% reduction in overtime hours from 2008-09 by March 31, 2010 • 5% reduction in the number of WCB time lost claims / days lost compared to 2008-09 by March 31, 2010 • 5% reduction in employee sick time hours compared to 2008-09 by March 31, 2010	**Analysis of Progress:** Target not achieved. 1.8% reduction achieved. Action plan has been identified to address overtime hours. There was a significant reduction in the number of lost days (17.1%), there was an increase in the number of claims (6.6%). The Region is developing a standardized process for responding to workplace injuries. A pilot project has been implemented at MJUH effective January 2010. Plan to expand throughout the Region. Target not achieved. 0.31% reduction achieved. The Region has a number of initiatives underway aimed at improving attendance. A 21-week project utilizing Lean principles has been completed in three departments. A 17.47% reduction year over year has been achieved across the participating departments. This process will be applied throughout other departments.

...cont...

Goal 2.3 The health sector has a highly skilled, professional and diverse workforce with a sufficient number and mix of service providers

Strategy	2.3.1 To establish the health sector as a workplace that is effective at retaining and recruiting workers		
Key Action 2.3.1.3 To improve staff engagement and inform the development of the Regional Health Authority's retention strategies by undertaking, analyzing and acting on the results from regular and ongoing staff surveys, and by establishing Board approved targets for improvement in the areas of concern identified by staff To work with the Ministry and the Saskatchewan Union of Nurses (SUN) to fill vacant SUN nursing positions and increase their total SUN FTEs. To establish a Joint SUN / Health Region Retention and Recruitment Committee to provide a formal process to involve nurse managers and front line staff to jointly problem solve, develop and agree on recruitment and retention initiatives to be delivered by the parties	**Measures:** • Achievement of SUN Partnership targets • Comprehensive staff survey by December 31, 2009	**Target**: • 75% of SUN FTE (straight time) recruitment targets achieved by March 31, 2010, to provide total SUN straight time FTEs of: • Board approved plan for targeted improvements by May 31, 2010	**Analysis of Progress:** In the 4th quarter, 60% of SUN recruitment targets were achieved. Positions will be added in keeping with service/program needs. Initial survey was completed in August 2009 with a follow up survey regarding professional development and continuing education in January 15, 2010. As a result, several recruitment and retention proposals have been developed and implemented in the Region.
Key Action 2.3.1.4 To develop a 10 year comprehensive health human resource plan that builds on all of the learnings from recruitment and retention initiatives recently sponsored and the Patient First Review **(Ministry)**	**Measures:** • Status of the new 10-year health human resource plan	**Target**: • New 10 year health human resources plan is complete by March 31, 2011	**Analysis of Progress:** The first draft of the plan is to be completed by August/September 2010 with implementation to begin by January 2011.

...cont...

Goal 2.3 The health sector has a highly skilled, professional and diverse workforce with a sufficient number and mix of service providers

Strategy	2.3.1 To establish the health sector as a workplace that is effective at retaining and recruiting workers		
Key Action 2.3.1.5 To continue to implement government's commitment, in collaboration with Advanced Education, Employment and Labour (AEEL) to create 40 new undergraduate (physician training) and 60 new post-graduate (residency training) seats as part of the Physician Training Strategy **(Ministry)**	**Measures:** • Status of new undergraduate seats and new post-graduate seats	**Target:** • Undergraduate Seats – 84 seats by September 30, 2009 and 100 seats by September 30, 2011 • Post-Graduate Seats – 108 seats by July 31, 2009 and 120 seats by July 31, 2011	**Analysis of Progress:** Ministry initiative
Key Action 2.3.1.6 To work with stakeholders to strengthen recruitment and retention efforts to increase the number of doctors in Saskatchewan including the development of a physician recruitment strategy **(Ministry)**	**Measures:** • Annual physician turnover • Retention of U of S medical graduates • Status of a distributed medical education model that exposes students and residents to practice in Saskatchewan • Reliance on foreign-trained physicians	**Target:** • Reduce the annual turnover of physicians in Saskatchewan to under 10% by 2013 • Increase the number of U of S medical graduates establishing practices in Saskatchewan by 10% by 2013 • Increase the number of U of S medical students and residents exposed to training opportunities outside of Saskatoon by 25% by 2013 • Increase the percentage of Canadian trained doctors working in Saskatchewan by 10% by 2013	**Analysis of Progress:** Ministry Initiative

3.0 SUSTAINABILITY			
Goal 3.2 **The health system has the required operating resources, equipment, capital and electronic infrastructure**			
Strategy	**3.2.1 To improve the quality, efficiency, and cost effectiveness of the health system by ensuring access to the required equipment, capital and electronic infrastructure**		
Key Action 3.2.1.1 To achieve full adoption and use of the electronic medical record over time **(Ministry)**	**Measures:** • % of practising physicians who have a fully implemented electronic medical record (EMR)	**Targets:** • 25% by March 31, 2010 • 80% by March 31, 2014	**Analysis of Progress:** No data received from Ministry to date.
	• % of practising physicians who routinely use the Pharmaceutical Information Program for both prescribing and patient management purposes	• 25% by March 31, 2010 • 80% by March 31, 2014	
	• % of practising physicians who have participated in a CDM collaborative and who routinely and fully use the CDM Toolkit	• 50% by March 31, 2011	

...cont...

Goal 3.2 The health system has the required operating resources, equipment, capital and electronic infrastructure

Strategy	3.2.1 To improve the quality, efficiency, and cost effectiveness of the health system by ensuring access to the required equipment, capital and electronic infrastructure		
Key Action 3.2.1.2 To undertake and complete the Ministry approved capital improvement projects targeted to long-term care facilities and addictions facilities, and address priorities in capital maintenance identified in the VFA study and by RHAs	**Measures:** • Status of capital improvement projects as of September 30, 2009 and March 31, 2010	**Target**: Progress on / completion of the following approved capital projects (timeframes to be added): Five Hills: • Moose Jaw Union Hospital Planning • Life Safety / Emergency and Infrastructure Projects • Pioneers Village Housing Units • Replacement Long Term Care building in Moose Jaw (Pioneers & Extendicare)	**Analysis of Progress:** Moose Jaw Union Hospital Planning – RFP issued, evaluated and awarded. Planning work will commence September 2010 with targeted completion date of September 2011. Infrastructure Projects – Progress update submitted to Ministry of Health, Capital and Regional Services Branch May 5, 2010 (projects are completed, in progress or funding committed). Pioneers Village Housing Units – Regional Facilities Master Plan to be budgeted in 2011-2012 and to be completed by March 31, 2013. Replacement Long Term Care Building in Moose Jaw – Regional Facilities Master Plan to be budgeted in 2011-2012 and to be completed by March 31, 2013.
Key Action 3.2.1.3 To develop a 10 year capital plan (facilities, equipment and information technology) which will incorporate environmental stewardship practices **(Ministry)**	**Measures:** • Status of Planning Framework • Status of Planning Document	**Target**: • Planning Framework in place by June 30, 2009 • Planning Document in place by March 31, 2010	**Analysis of Progress:** VFA 2007 Facility Condition assessments serve as guide for 20 year capital plan. Master Plan for all facilities to be developed. Regional Facilities Master Plan to be budgeted in 2011-2012 and to be completed by March 31, 2013. Approval to proceed conditional on resource availability. Primary Health Care (PHC) team in Moose Jaw in process of implementing "PHC Solution" (electronic health record). Learnings from the implementation will be used to prepare and implement in other PHC teams across region.

Financial Summary

The annual operating budget for 2009-10 was $121.0 million. The actual operating fund revenues were $127.9 million and operating fund expenses were $125.9 million; resulting in an operating fund surplus of $2.1 million (1.6% of operating expenses).

Overall, 93% of the operating fund revenue was provided by funding from the Ministry of Health. About 44% of the operating budget was spent on hospital services, 31% on long term and supportive care, 17% on community-based/public health/primary care/home care services, 4% on program support and administration and 4% on other. Approximately 79% of the annual budget was spent on salaries and benefits (includes grants to contractors).

Subsequent to budget approval, additional funding was finalized in the amount of $ 4.4 million for the Service Employees International Union (SEIU) outstanding collective bargaining agreement as at March 31, 2010. In addition, $.6 million was received for H1N1 pandemic related expenses and $0.4 million for additional nursing positions through the SUN Partnership Agreement.

The capital fund expenditures for 2009-10 were $7.4 million with 33% being spent on medical/surgical equipment, 9% on diagnostic imaging equipment, 40% on building and building service equipment, 8% for capital grants to health care organizations and 3% for mortgage obligations.

Future Outlook/Emerging Issues

Future Prospects

The Strategic Directions detailed by the Ministry of Health, including the Five Pillars for 2010-2011, provide the Region with the necessary focus and alignments in determining priorities. Some of our priorities (not all inclusive) are as follows:

1. **Health of the Individual**

   Customer Services and the Recommendations from the Patient First Review

   This year, 2010-2011, we will continue with education of our employees incorporating patient stories as part of the learning modules with the goal to improve the patient/customer experience to be exceptional.

2. **Providers**

   Attendance management and workplace safety requires engagement of all staff with attention to strategies with the goal of creating safe, supportive, quality workplaces.

   Physician recruitment and retention continues to be a priority and we will work collaboratively with the provincial Physician Recruitment Agency.

3. **Supporting Processes;** and
4. **Sustainability**

   Pursuing Excellence will focus on four priority areas, applying Lean principles:

   Discharge Planning
   Medication Reconciliation
   Releasing Time to Care
   Workplace Safety/Sick Time

   Redevelopment of Moose Jaw Union Hospital, applying Lean principles with the objective to identify multiple construction options and provide decision makers with enough detailed information to allow for confirmation of the scope and cost of an optimal solution.

5. **Health of the Population**

   The Region will continue the development of Primary Health Care teams continuing with Health Quality Council collaboratives and a focus on Clinical Practice Redesign.

Risk Management

Some future risks in achieving the future priorities noted above are as follows:

Infection Control and Pandemic Planning
Infection Control practices and pandemic planning in concert with other health regions and the Ministry continues to be a priority.

Staff Recruitment and Retention
This will be an increasing challenge as the health region responds to the demographic reality of the population.

Patient Safety

System redesign needs to take place in order to match the safety standard of other industries, such as the airline industry.

Capital Infrastructure
Rigid building designs will need to evolve with the change in needs and evolution of services. In conjunction with primary health care reform, the acute care system will need to be redesigned to address **chronic and complex care needs** that are emerging.

Changing Health Needs and Trends
Chronic illness care continues to emerge as the prevalent need in the population. The upstream challenge of obesity and a lack of physical activity will increase this strain on the health system. At the other end of the spectrum, the number of outbreaks and the risk of pandemic will also rise.

Access Issues
Patients continue to deal with access issues related to a lack of transportation, unnecessary waits for health services and a lack of access to telehealth and telehome care alternatives. Access to surgery within appropriate timelines for citizens of this province continues to be a high priority. Addressing and improving the surgical experience remains a priority.

Multiple Acute Care Systems
The patient journey is most likely to begin in a setting outside of the Health Region service – perhaps within a physician's office. The system of referral and information flow is poorly designed and requires modernization and standardization. In addition, patient flow between facilities, services and regions needs improvement as every handoff creates a risk of error and miscommunication. The lack of **information systems** to assist in what is currently a paper system need further focus.

Demographic Changes
The population of the region is predicted to continue to decline. If past trends continue, out-migration from rural areas will be the most pronounced. The senior population will decline, only to peak again in 14 years with an aging baby boomer population. Retention of the young workforce, representing a source for future health workers and the future tax paying generation, will be a continued challenge. Services cannot and should not be sustained at their current levels. Services must evolve to meet the ever changing population needs.

Payee Disclosure

Personal Services

Listed are individuals who received payments for salaries, wages, honorariums, etc. which total $50,000 or more.

Aasen, Dianne	96,735
Ackerman, Linda	89,428
Adewumi, Adegboyeg	254,955
Adrian, Shelly	64,975
Albinet, Laurie	119,658
Alderton, Cheryl	58,826
Allen, James	92,119
Alraum, Isolde	81,610
Altwasser Bryant, Arla	72,357
Ambrose, Shelley	54,203
Amies, Michael	86,390
Anderson, Darrell	79,608
Anderson, Lori	86,026
Arseneau, Maureen	88,876
Awad El Kariem, Sawsan	345,112
Ayers, Nola	150,648
Bain, Joy	90,322
Bakke, Krista	85,904
Ballard, Geraldine	86,099
Barnett, Krista	50,022
Barrett, Elizabeth	69,414
Barth, Darlene	50,357
Bartzen, Della	54,307
Bastedo, J. Roger	85,489
Batty, Kathy	70,152
Bauck, Deborah	82,941
Beaubien, Colette	81,100
Beauregard, Claude	54,777
Beausoleil, Aline	52,221
Beesley, Craig	122,884
Bellrose, Sheila	67,622
Bender, Blaine	50,852
Bender, Karen	77,341
Bengtson, Monica	63,019
Bennett, Dawn	53,522
Benoit, Ann	99,023
Benson, Lisa	71,217
Bergen, Rachel	70,386
Berjian, Florence	59,727
Berthelet, Robin	81,452
Blazieko, Joann	87,870
Blazieko, Wayne	139,451
Bohlken, Dawn	58,654
Boire Teixeira, Louise	57,588
Bookout, Karen	58,523
Booth, Mary Lee	92,119
Boothman, Tami	83,967
Bourassa, Crystal	63,153
Bouvier, Coralee	58,346
Bouvier, Laurie	54,646
Box, Kimberley	76,507
Boyczuk, Christine	81,043
Bremner, Carolyn	99,200
Brenner, Teresa	64,975
Brinton, Peggy	86,148
Brisbin, Katherine	67,739
Broeder, Teresa	118,290
Brunke, Kirstin	57,414
Buchanan, Robert	67,289
Budd Wutke, Darla	86,098
Bumphrey, Brenda	89,189
Burnett, Barbara	67,672
Burns, Maureen	89,355
Bushell, Marlene	52,300
Butlin, Barbara	59,624
Cairns, Myles	69,219
Campbell, Carol	58,729
Campbell, Nimone	79,530
Campbell, Patricia	59,503
Campbell, Shauna L	97,806
Campbell, Wanda	85,074
Camphaug, Shawna	56,270
Carretero, Antonio	293,450
Carruthers, George	109,275
Cayer, Janice	82,382
Chaisson, Alfred	54,205
Chaisson, Clara	98,541
Chartrand, Lisa	62,035
Chow, Amy	67,550
Clark, Carol	53,579
Clayson, Tabithia	54,245
Cobb, Charlene	62,870
Cobbe, Carmen	51,542
Cochrane, Rod	82,620
Cole, Brenda	54,761
Cole, Lorlee	55,318

Cooke, Liana	56,085
Cooper, Cindy	50,089
Cossette, Rondelle	69,062
Cotter, Debra	108,673
Cox, Sheila	96,814
Craig, Cheryl	261,818
Cristo, Janet	67,000
D Entremont, Marc	63,632
Dancey, Colleen	85,057
Demassi, Kristy	54,867
Deobald, Brenda	95,431
Deringer, Gina	79,396
Dick, Denise	86,071
Dixon, Karen	76,935
Doepker, Bernie	66,744
Doerksen, Kim	52,066
Dombowsky, Eva	52,502
Donley, Teresa	94,145
Dowling, Michelle	90,767
Downey, Corrin	60,334
Downie, Suzanne	129,876
Dreger, Wanda	72,729
Driedger, Heather	79,206
Durand, Sylvia	67,113
Dushinski, Kim	85,904
Duzan, Nancy	56,408
Dyck, Diane	64,688
Ebbett, Pamela	57,166
Elford, Denae	68,128
Ellert, Clara M	65,633
Ellingson, Marie	85,503
Elson, Andrea	97,613
Engler, Kathryn	89,493
Engstrom, Leslie	74,453
Engstrom, Pamela	81,383
Erskine, Kimberly	75,701
Erwin, Dre	82,893
Etches, Robert	303,449
Farwell, Faye	57,259
Ferguson, Dianne	108,607
Ferguson, James	66,752
Fernell, Karen	81,325
Ferraton, Tamara	61,533
Fieldgate, Catherine	83,080
Filipowich, Kathleen	75,444
Firomski, Curtis	52,631
Fitterer, Cheryl	60,274
Fitzpatrick, Gail	70,514
Fjeldberg, Rynae	101,650
Flegel, Deborah	84,530
Flegel, Elaine	68,783
Flowers, Barbara	56,576
Fogal, Stacey	55,709
Forrest, Lois	96,601
Fowler, Sandra	64,604
Francoeur, Lisa	74,134
Frank, Gwenith	88,048
Fraser, Dan	99,200
Froehlich, Deneen	66,077
Froehlich, Kelly	74,719
Fryklund, Susan	61,264
Gadd, Svetlana	80,643
Galenzoski, Shelley	51,556
Gallup, Kelsey	54,763
Gaucher, Adrien	95,355
Gee, Teresa	90,460
Gilbert, Chere	85,007
Gilbert, Natasha	57,080
Gillies, Jennifer	61,180
Gleim, Sandra	82,047
Godin, Fairlie	66,844
Good, Laurie	92,436
Goodison, Melonie	86,915
Goslin, Erin	54,469
Goud, Dan	64,479
Goudie, Darlene	93,770
Graham, Crystal	56,290
Grant, Mathilda	84,277
Gray, Deborah	65,272
Green, Janice A	74,183
Griffin, Kathy	93,631
Gross, Edith	53,237
Guillaume, Allyson	87,434
Gummeson, Phyllis	69,219
Gyrlevich, Louise	87,260
Haas, Erin	76,314
Hadley Cole, Rona	85,001
Hagan, Gayle	72,193
Hager, Brad	66,263
Handfield, Leslie	52,552
Hanson, Teresa	76,254
Haque, Sameema	84,311
Hasenack, Lisa	55,727
Hasmatali, Sheryl	95,343
Hassler, Sandra	90,125
Haukaas, Brenda	86,983
Hayward, Grace	73,548
Heath, Stacey	76,984
Heidecker, Christine	52,285
Heidecker, Kirk	85,816
Hein, Kristen	68,604
Helland, Joanne	74,373

Hicks, Dorothy	52,823
Hicks, Pat	89,127
Hogg, Jolene	77,274
Howick, David	50,127
Huber, Marvin	85,904
Hudson, Donna	84,170
Hugg, Shauna	85,084
Hughes Mook, Marion	51,962
Hundeby, Janet	83,467
Hutchinson, Terry	125,950
Ingram, Larai	55,966
Ireland, Diane	112,638
Ireland, Sharon	64,273
Jago, Terry	74,306
Johnson, Allyson	68,765
Johnson, Cynthia	87,363
Johnson, Darren	92,917
Johnson, Elaine	86,817
Johnson, Heather	85,412
Johnson, Pamela	80,134
Johnson, Wayne	85,290
Juell, Jody	78,684
Jukes, Jackalyn	70,424
Justason, Ave Berna	84,607
Karst, Teresa	93,496
Keall, Sylvia	72,461
Keddy, Roben	54,757
Kergan, Guy	85,904
Kerr, Daniel	51,886
Kimball, Sandra	54,193
Kindrachuk, Joye	87,550
Kittler, Shelly	86,438
Kitts, Lynn	72,777
Knapp, Glen	54,323
Knelsen, Sharon	75,582
Knudson, Katherine	64,785
Kowalski, Gwen	93,450
Krepakevich, Kevin	85,882
Kuhn, Joanne	58,573
Kwan, Rhonda	77,999
Lalonde, Janet	87,316
Lambert, Colleen	89,374
Langdon, Karyn	87,869
Langlois, Paul	62,288
Larmour, Brent	80,025
Law, Linda	86,034
Le Courtois, Robin	81,880
Lehmann, Karen	62,196
Lewis, Shawna	80,626
Lewry, Patricia	55,294
Liguori, John	125,499
Longworth, Linda	54,349
Lorencz, Therese	63,923
Lovick, Valerie	100,382
Lowenberg, Candace	86,300
Lowes, Joanne	65,501
Ludke, Mona	75,070
MacDiarmid, Joyce	99,200
MacFarlane, Tracy	52,675
Mackenzie, Dawnidell	55,548
MacPherson, Stacey	72,149
Marciszyn, Anne	62,051
Martyniuk, Bonita	92,152
Mattus, Donna	64,668
Mazurkiewicz, Jaclyn	62,994
McBride, Shirley	64,934
McCormack, Evelyn	90,136
McDavid, Cara	54,287
McDowell, Ashleigh	70,103
McFadden, Brandy	88,358
McInnes, Maryellen	97,297
McKay, Holly	59,050
McKenna, Joann	58,944
McKinley, Lynde	100,062
McMaster, Rhonice	75,482
McNeil, Elaine	89,403
Medders, Steve	53,947
Melby, Nicole	63,565
Merifield, Danielle	80,036
Messner, Donna	63,766
Mielke, Janice	70,518
Millar, Frances	98,015
Miller Moyse, Gwen	58,674
Miller, Gail	52,449
Miller, Lenore	53,056
Miller, Tamye	76,399
Miskiman, Chad	95,068
Molde, Helen	87,804
Molsberry, Marjorie	52,375
Monea, Deborah	80,011
Montgomery, Marie	84,073
Moore, Jean	77,326
Moran, Shelley	75,176
Morland, Darlene	97,208
Moulding, Donna	95,138
Myers, Linda	70,053
Neal, Sheila	69,429
Neigel, Darcy	75,856
Nelson, Bonnie	81,490
Newans, Robin	88,751
Nicholls, Brenda	94,308
Nicholson, Raelynn	59,687

Nicolay, Sheree	54,017
Nicolson, Sharon	85,904
Nightingale, Laurianne	102,854
Nikolic, Shelley	51,409
Noseworthy, Daisy	50,972
Nouh, Mohamed	367,850
Oen, Barb	57,152
Ofstedahl, Donna	83,190
Ofukany, Lindsey	71,339
Ogle, Wanda	85,904
Oledzki, Joan	50,219
Ollenberg, James	68,712
Onugha, Edward	149,296
Oram, Dianne	73,351
O'Reilly, Audrey	79,962
Osemlak, Pauline	99,200
Oshowy, Haley	54,338
Pardy, Arlene	87,756
Parker, Lisa	66,304
Passmore, Arlene	50,388
Paul, Connie	79,985
Paull, Elizabeth	81,630
Paulowicz, Jeffrey	66,034
Paysen, Angie	55,904
Pearson, Shannon	54,817
Pecusik, Catherine	97,091
Petersen, Joanne	74,942
Peterson, Eyvonne	99,353
Peterson, Lance	66,690
Peterson, Serena	78,625
Petruic, Judy	56,808
Philipation, Dana	53,249
Philipation, Travis	74,663
Pieper, Hayley	81,973
Pinkney, Carla	59,593
Polos Fox, Shelley	51,158
Pouteaux, Sarah	57,209
Preston, Peggy	65,700
Prokopchuk, Arlene	73,675
Puckett, Lynn	94,334
Ramphal, Christine	67,210
Reaman, Viola	73,969
Reed, Eveline	87,735
Reihl, Debbie	70,640
Remoue, Marilyn	72,372
Rice, Christine	87,938
Richardson, Brian	75,802
Rivard, Wendy	68,828
Roach, Shelley	94,772
Robb, Donna	72,139
Roberts, Christa	64,301
Robertson, Jackie	89,830
Rodgers, Marilyn	77,450
Rollie, Wendy	88,785
Rossler, Vanessa	51,018
Rudd, Nola	67,529
Rumancik, Peter	70,571
Rusnak Weekes, Nicole	66,004
Rust, Johanne	106,555
Rusu, Troy	62,968
Ruzicka Olson, Corie	64,844
Ryan, Beverley	87,030
Sabourin, Dolores	50,373
Salaba, Janice	86,673
Saladana, Rita	86,084
Salido, Deign	79,708
Salido, Joanne	51,990
Sanden, Wendy	71,718
Sanders, Anita	87,010
Sanderson, Lois	54,131
Savage, June	80,111
Schick, Joyce	55,338
Schnare, Gwen	50,166
Schutte, Greg	68,324
Scott, Deborah	90,440
Segall, Heather	100,011
Seida, Norine	99,200
Seip, Kim	71,110
Seman, Edward	67,802
Sereda, Dave	61,064
Shelstad, Cynthia	98,421
Shiers, Mark	87,650
Shirkey, Patti	71,131
Silvester, Paul	78,836
Silzer, Sharon	61,786
Simmons, Lorna	78,182
Sinclair, Juliet	86,584
Smith, Brenda L.	61,427
Smith, Brenda S.	80,188
Smith, Darlene	100,011
Smith, Donna	70,200
Smith, Marlene	53,721
Smith, Shelley	86,191
Sobottka, Bonnie	98,243
Sparks, Debbie	62,779
Spence, Laura	67,940
Stabell, Susan	61,399
Stankewich, Brenda	57,556
Stapor, Paul	79,935
Statham, Cheri	93,808
Steckhan, Edna	64,986
Steel, Brenda	68,153

Stenerson, Wade	59,858
Stensland, Jana	102,135
Stevens, Debra	80,569
Stewart, Cathy	93,704
Stewart, Shannon	52,423
Stobbs, John	59,036
Storozuk, Yvette	78,518
Strand, Cherise	52,315
Strange, Debra	82,885
Straub, Jacquelin	90,133
Striha, Lynn	87,629
Strom, Shelda	70,366
Sullivan, Maureen	94,667
Swanson, Kerry	67,937
Switzer, Betty	90,015
Tallon Dyck, Holly	68,598
Tendler, Cathy	57,816
Terry, Ernest	106,351
Thul, Lori	54,349
Thul, Louise	98,561
Tipper, Lisa	60,906
Tkachuk, Brian	81,460
Tomashewski, Tannis	60,620
Trafford, Karen	52,721
Tremaine, Shari	62,866
Trusty, Alice	90,351
Tysdal, Elizabeth	56,892
Ursan, James	51,796
Uy, Narath	50,335
Vaessen, Leisa	86,045
Vatamaniuk, Lisa	63,272
Vooght, Mark	218,594
Voth, Norlaine	68,882
Waldenberger, Vanessa	89,630
Waldon, James	64,670
Walker, Vivian	50,028
Wanner, Brian	83,728
Ward, Cheryl	84,420
Wasylenka, Dixie	89,328
Watson, Donna	74,530
Wells, Karen	50,421
White, Patricia	54,036
Wicharuk, Judy	89,075
Willatt, Linda	72,533
Williams, Shannon	64,544
Willis, Megan	79,908
Wilm, Joanne	99,386
Winkler, Lucyna	81,573
Winter, David	84,317
Wittal, Gerrilynn	96,399
Wolfe, Jacquelin	87,177
Woloschuk Connor, Laurie	66,779
Wong, Gail	50,333
Wood, Darcy	67,462
Work, Jodi	67,814
Wostradowski, Bonnie	54,239
Wozniak, Yvonne	83,628
Yaschuk, Kerry	71,905
Yost Walter, Lynda Lee	83,736
Young, Vanessa	66,273
Zarubin, Amanda	85,664
Payees under $50,000	25,218,638
Total Personal Services	**60,750,105**

Transfers

Listed, by program, are transfers to recipients who received $50,000 or more

Extendicare	6,424,556
Hutch Ambulance	527,798
Individualized Home Care Funding	228,536
Moose Jaw Alcohol & Drug Abuse Society Inc.	1,013,169
Moose Jaw and District EMS	1,395,226
Moose Jaw Transition House	234,804
Providence Place	12,645,912
Salvation Army	149,538
St. Joseph's EMS Gravelbourg	241,315
St. Joseph's Hospital Gravelbourg	4,898,245
Thunder Creek Rehab Assoc Inc.	686,283
Total Transfers	**28,445,382**

Suppliers

Listed are payees who received $50,000 or more for the provision of goods and services, including office supplies, communications, contracts and equipment.

Abbott Laboratories Ltd.	507,246
Al-Begamy, Dr. Youssef	234,082
LM Architectural Group	205,276
London Life	54,753
Louw, Dr. Alexander Francois	79,258
Maree, Dr. Narinda Medical Prof.	375,202
Marsh Canada Limited	188,747
Marx Medical Prof Corp.	167,443
McKesson Canada	411,089
McKesson Distribution Partners	156,449
Mid West Efficiency Heating	132,937
Minister Of Finance	789,967
Moose Jaw & District EMS	147,222
Moose Jaw Alcohol & Drug Abuse	57,850
Moose Jaw Times Herald	58,615
Moose Jaw YMCA	110,722
Mouton, Dr. Andries	196,495
Nagel, Marjorie	75,397
Naidu, Dr. Kuben	92,686
Otis Canada Inc.	52,009
Oyenubi, Dr. Abimbola	251,115
Pansegrouw Medical Prof. Corp.	305,574
Pentax	296,503
Pepsi Bottling Group	50,268
Philips Electronics Ltd.	295,723
Prairie Janitorial Supply	59,375
Prairie Meats	62,338
Prairie North Health Region	81,133
Public Employees Pension Plan	238,758
Puetz, Dr. Joel	141,943
Ramadan, Dr. Fauzi Medical Prof	124,784
Receiver General For Canada	20,731,974
Retief, Dr. Leon	345,339
Rossouw, Dr. Stephanus	193,484
SAHO	333,457
SAHO Dental Plan	810,565
SAHO DIP	1,571,417
SAHO Extended Health & Dental	1,785,631
Sanderson, Dr. Brian J.	60,177
Saputo Foods Limited	151,959
Sask Energy	749,753
Sask Power	1,058,130
Sask Registered Nurses Assoc.	167,922
Sask Tel CMR	218,275
Sask Tel Mobility	87,934

Sask Workers' Compensation Board	1,129,343
Saskworks Venture Fund Inc.	104,753
Schaan Healthcare Products Inc.	1,144,864
Security Patrol & Investigators	98,210
SEIU Local 299 MJ	535,622
Shanthakumar, Dr. Ratnasingham	196,998
SHEPP	8,934,399
Shopper's Home Healthcare	563,702
Siemens Healthcare Diagnostics	136,182
Source Medical	462,160
Soyege, Dr. Adeloye	168,939
St Joseph's Hospital Gravelbourg	134,364
Stantec	128,593
Steris Canada Inc.	654,133
Stevens Company Limited	283,673
Stryker Canada Inc.	112,756
SUN Provincial	354,779
Sunspun Food Service	144,975
Supreme Office Products Ltd.	266,675
Sysco Food Services	646,723
Thorpe, Dr. R. Brandon	71,470
Toshiba	557,152
Toshiba Business Solutions	67,250
Tyco Healthcare Group Canada	306,272
Valley View Centre	1,056,148
Van Der Merwe, Dr. Ivann	96,165
Van Der Merwe, Dr. Schalk	312,202
Van Wyk, Dr. Gerrit Prof. Corp.	482,568
Vertue, Dr. Peter-John	67,361
Vitalaire	109,285
Yeboah, Dr. Emmanual K.	73,072
Zimmer Canada	212,445
Zonare Medical Systems Canada	76,450
Supplier Payments under $50,000	6,738,104
Total Supplier Payments	**70,042,857**

Management Report

May 7, 2010

Five Hills Health Region
Report of Management

The accompanying financial statements are the responsibility of management and are approved by the Five Hills Regional Health Authority. The financial statements have been prepared in accordance with Canadian Generally Accepted Accounting Principles and the Financial Reporting Guide issued by Saskatchewan Health, and of necessity include amounts based on estimates and judgments. The financial information presented in the annual report is consistent with the financial statements.

Management maintains appropriate systems of internal control, including policies and procedures, which provide reasonable assurance that the Region's assets are safeguarded and the financial records are relevant and reliable.

The Authority delegates the responsibility of reviewing the financial statements and overseeing Management's performance in financial reporting to the Finance and Audit Committee. The Finance and Audit Committee meets with the Authority, management and the external auditors to discuss and review financial matters and recommends the financial statements to the Authority for approval. The Authority approves the annual report and, with the recommendation of the Finance and Audit Committee, approves the financial statements.

The appointed auditor conducts an independent audit of the financial statements and has full and open access to the Finance and Audit Committee. The auditor's report expresses an opinion on the fairness of the financial statements prepared by Management.

Cheryl Craig, BSN
Chief Executive Officer

Wayne Blazieko, CMA, MSA, B. Admin
Chief Financial Officer

2009-2010 Financial Report

AUDITORS' REPORT

To the Five Hills Regional Health Authority

We have audited the statement of financial position of the Five Hills Regional Health Authority as at March 31, 2010 and the statements of operations and changes in fund balances and cash flow for the year then ended. These financial statements are the responsibility of the Authority's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of Five Hills Regional Health Authority as at March 31, 2010 and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Virtus Group LLP

Regina, Saskatchewan
May 7, 2010

CHARTERED ACCOUNTANTS

Statement 1

FIVE HILLS REGIONAL HEALTH AUTHORITY
STATEMENT OF FINANCIAL POSITION
As at March 31, 2010

	Operating Fund	Restricted Funds: Capital Fund	Restricted Funds: Community Trust Fund	Total 2010	Total 2009 (Note 10)
ASSETS					
Current assets					
Cash and short-term investments (Statement 3)	$ 23,724,770	$ 18,070,391	$ 136,471	$ 41,931,632	$ 36,088,591
Accounts receivable					
Ministry of Health - General Revenue Fund	502,863	-	-	502,863	322,686
Other	714,469	39,222	19,543	773,234	896,468
Inventory	1,139,695	-	-	1,139,695	863,368
Prepaid expenses	1,099,552	-	-	1,099,552	1,123,606
	27,181,349	18,109,613	156,014	45,446,976	39,294,719
Investments (Note 2, Schedule 2)	31,579	686,934	798,928	1,517,441	1,559,570
Capital assets (Note 3)	-	19,237,850	-	19,237,850	16,936,452
Total Assets	$ 27,212,928	$ 38,034,397	$ 954,942	$ 66,202,267	$ 57,790,741
LIABILITIES & FUND BALANCES					
Current liabilities					
Accounts payable	$ 4,595,702	$ 11,315	$ -	$ 4,607,017	$ 3,867,334
Accrued salaries	5,520,859	-	-	5,520,859	2,860,593
Vacation payable	5,718,609	-	-	5,718,609	5,420,857
Mortgages payable – Current (Note 5)	-	118,238	-	118,238	112,190
Deferred Revenue (Note 6)	10,149,856	-	-	10,149,856	4,982,201
	25,985,026	129,553	-	26,114,579	17,243,175
Long Term Liabilites					
Long term leases payable	-	-	-	-	-
Mortgages payable (Note 5)	-	1,786,629	-	1,786,629	1,904,593
Total Liabilities	25,985,026	1,916,182	-	27,901,208	19,147,768
Fund Balances					
Invested in capital assets	-	17,332,983	-	17,332,983	14,919,669
Externally restricted (Schedule 3)	-	5,892,066	954,942	6,847,008	10,565,687
Internally restricted (Schedule 4)	-	12,893,166	-	12,893,166	13,157,617
Unrestricted	1,227,902	-	-	1,227,902	-
Fund balances – (Statement 2)	1,227,902	36,118,215	954,942	38,301,059	38,642,973
Total Liabilities & Fund Balances	$ 27,212,928	$ 38,034,397	$ 954,942	$ 66,202,267	$ 57,790,741

Commitments (Note 4)
Mortgages (Note 5)
Pension Plan (Note 11)

Approved by the board of directors:

The accompanying notes and schedules are part of these financial statements.

FIVE HILLS REGIONAL HEALTH AUTHORITY
STATEMENT OF OPERATIONS AND CHANGES IN FUND BALANCES
For the Year Ended March 31, 2010

	Operating Fund			Restricted			
	Budget 2010	2010	2009 (Note 10)	Capital Fund 2010	Community Trust Fund 2010	Total 2010	Total 2009 (Note 10)
REVENUES							
Ministry of Health - General	$ 113,691,058	$ 119,064,298	$ 109,578,453	$ 961,434	$ -	$ 961,434	$ 9,996,226
Other provincial	429,415	880,553	490,885	47,774	-	47,774	45,471
Federal government	97,800	140,761	151,266	-	-	-	-
Funding from other provinces	-	-	-	-	-	-	-
Special funded programs	875,251	923,126	909,332	-	-	-	-
Patient fees	3,477,400	3,667,436	3,535,588	-	-	-	-
Out of province (reciprocal)	686,800	803,135	782,407	-	-	-	-
Out of country	64,400	8,632	86,475	-	-	-	-
Donations	6,300	82,278	53,722	1,481,004	-	1,481,004	697,897
Investment	121,701	109,047	427,596	143,303	21,436	164,739	369,578
Ancillary	157,238	161,033	143,619	20,600	-	20,600	20,600
Recoveries	1,400,865	2,041,550	1,896,630	-	-	-	-
Other	15,850	51,593	21,057	40,803	-	40,803	27,197
Total revenue	121,024,078	127,933,442	118,077,030	2,694,918	21,436	2,716,354	11,156,969
EXPENSES							
Province wide acute care services	1,715,330	1,552,870	1,478,857	94,805	-	94,805	284,575
Acute care services	42,670,221	44,495,792	40,656,668	2,991,519	-	2,991,519	2,501,443
Physician compensation - acute	6,921,206	6,973,275	6,548,051	-	-	-	-
Supportive care services	36,477,943	38,593,071	35,185,221	1,764,719	-	1,764,719	1,383,339
Home based service - supportive care	5,925,451	6,445,769	5,930,967	8,730	-	8,730	11,326
Population health services	3,590,645	3,721,931	3,358,339	14,713	-	14,713	20,573
Community care services	6,249,099	6,267,976	5,810,906	5,346	-	5,346	-
Home based services - acute & palliative	1,233,137	1,350,182	1,244,642	-	90,685	90,685	87,206
Primary health care services	1,709,657	1,801,861	1,602,751	29,392	-	29,392	85,957
Emergency response services	2,612,836	2,671,162	2,653,234	3,637	-	3,637	3,011
Mental health services - inpatient	2,429,916	2,908,296	2,506,249	5,391	-	5,391	5,392
Addictions services - residential	957,314	957,314	883,477	40,249	-	40,249	-
Physician compensation - community	2,348,512	2,143,999	2,177,889	-	-	-	-
Program support services	5,082,204	4,879,313	4,693,516	58,365	1,900	60,265	76,797
Special funded programs	916,443	954,207	928,683	-	-	-	-
Ancillary	184,164	158,746	156,909	6,495	-	6,495	7,134
Total expenses (Schedule 1)	121,024,078	125,875,764	115,816,359	5,023,361	92,585	5,115,946	4,466,753
Excess (Deficiency) of revenues over expenses	$ -	2,057,678	2,260,671	(2,328,443)	(71,149)	(2,399,592)	6,690,216
Fund Balances, beginning of year		1,227,902	1,227,902	36,388,980	1,026,091	37,415,071	28,464,184
Interfund transfers (Note 14)		(2,057,678)	(2,260,671)	2,057,678	-	2,057,678	2,260,671
Fund balances, end of year		$ 1,227,902	$ 1,227,902	$ 36,118,215	$ 954,942	$ 37,073,157	$ 37,415,071

The accompanying notes and schedules are part of these financial statements.

FIVE HILLS REGIONAL HEALTH AUTHORITY
STATEMENT OF CASH FLOW
For the Year Ended March 31, 2010

	Operating Fund		Restricted Fund			
	2010	2009 (Note 10)	Capital Fund	Community Trust Fund	Total 2010	Total 2009 (Note 10)
Cash Provided by (used in):	**Operating Activities**		**Financing and Investing Activities**			
Excess (deficiency) of revenue over expenses	$ 2,057,678	$ 2,260,670	$ (2,328,442)	$ (71,149)	$ (2,399,591)	$ 6,690,216
Net change in non-cash working capital (Note 7)	8,554,588	2,166,395	(2,045)	3,597	1,552	13,596
Amortization of capital assets	-	-	4,254,713	-	4,254,713	3,978,043
Investment income on long-term investments	-	-	-	-	-	-
Gain/(loss) on disposal of capital assets	-	-	-	-	-	-
	10,612,266	4,427,065	1,924,226	(67,552)	1,856,674	10,681,855
Purchase of capital assets						
Buildings/construction	-	-	(2,239,664)	-	(2,239,664)	(435,452)
Equipment	-	-	(4,316,447)	-	(4,316,447)	(2,204,480)
Proceeds on disposal of capital assets						
Buildings	-	-	-	-	-	-
Equipment	-	-	-	-	-	-
Sale of long-term investment	47,216	(7,896)	19,625	(24,714)	(5,089)	(159,152)
	47,216	(7,896)	(6,536,486)	(24,714)	(6,561,200)	(2,799,084)
Repayment of debt	-	-	(111,915)	-	(111,915)	(105,976)
Net increase in cash & short term investments during the year	10,659,482	4,419,169	(4,724,175)	(92,266)	(4,816,441)	7,776,796
Cash & short term investments, beginning of year	15,122,966	12,964,468	20,736,888	228,737	20,965,625	10,928,158
Interfund transfers (Note 14)	(2,057,678)	(2,260,671)	2,057,678	-	2,057,678	2,260,671
Cash & short term investments, end of year (Schedule 2)	**$ 23,724,770**	**$ 15,122,966**	**$ 18,070,391**	**$ 136,471**	**$ 18,206,862**	**$ 20,965,625**

The accompanying notes and schedules are part of these financial statements.

FIVE HILLS REGIONAL HEALTH AUTHORITY
NOTES TO THE FINANCIAL STATEMENTS
As At March 31, 2010

1. Legislative Authority

The Five Hills Regional Health Authority (RHA) operates under *The Regional Health Services Act* (The Act) and is responsible for the planning, organization, delivery, and evaluation of health services it is to provide within the geographic area known as the Five Hills Health Region, under section 27 of The Act. The Five Hills RHA is a non-profit organization and is not subject to income and property taxes from the federal, provincial, and municipal levels of government. The RHA is a registered charity under the *Income Tax Act* of Canada.

2. Significant Accounting Policies

These financial statements have been prepared in accordance with Canadian generally accepted accounting principles and include the following significant accounting policies.

a) Health Care Organizations

i) The RHA has agreements with and grants funding to the following prescribed Health Care Organizations (HCOs) and third parties to provide health services:

Extendicare (Canada) Inc.
Moose Jaw Alcohol and Drug Abuse Society Inc.
Canadian Mental Health Association (Saskatchewan Division)
Thunder Creek Rehabilitation Association Inc.
Lifeline Ambulance Service Inc.
Wald Ambulance Ltd.
Hutch Ambulance Service Inc.

Note 9 b) i) provides disclosure of payments to prescribed HCOs and third parties.

ii) The following affiliates are incorporated as follows (and are registered charities under the Income Tax Act):

Providence Place for Holistic Health Inc. – *Non profit Corporations Act*
St. Joseph's Hospital (Grey Nuns) of Gravelbourg – *Non profit Corporations Act*

The RHA provides annual grant funding to these organizations for the delivery of health care services. Consequently, the RHA has disclosed certain financial information regarding these affiliates.

Note 9 b) ii) provides supplementary information on the financial position, results of operations, and cash flows of the affiliates.

b) Fund Accounting

The accounts of the RHA are maintained in accordance with the restricted fund method of accounting for contributions. For financial reporting purposes, accounts with similar characteristics have been combined into the following major funds:

i) Operating Fund

The operating fund reflects the primary operations of the RHA including revenues received for provision of health services from Saskatchewan Health - General Revenue Fund, and billings to patients, clients, the federal government and other agencies for patient and client services. Other revenue consists of donations, recoveries, and ancillary revenue. Expenses are for the delivery of health services.

ii) Capital Fund

The capital fund is a restricted fund that reflects the equity of the RHA in capital assets after taking into consideration any associated long-term debt. The capital fund includes revenues received from Saskatchewan Health - General Revenue Fund designated for construction of capital projects and/or the acquisition of capital assets. The capital fund also includes donations designated for capital purposes by the contributor. Expenses consist primarily of amortization of capital assets.

iii) Community Trust Fund

The community trust fund is a restricted fund that reflects community generated assets transferred to the RHA in accordance with the pre-amalgamation agreements signed with the amalgamating health corporations. The assets include cash and investments initially accumulated by the health corporations in the RHA from donations or municipal tax levies. These assets are accounted for separately and use of the assets is subject to restrictions set out in pre-amalgamation agreements between the RHA and the health corporations.

c) Revenue

Unrestricted contributions are recognized as revenue in the Operating Fund in the year received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Restricted contributions related to general operations are recorded as deferred revenue and recognized as revenue of the Operating Fund in the year in which the related expenses are incurred. All other restricted contributions are recognized as revenue of the appropriate restricted fund in the year.

d) Capital Assets

Capital assets are recorded at cost. Normal maintenance and repairs are expensed as incurred. Capital assets, with a life exceeding one year, are amortized on a straight-line basis over their estimated useful lives as follows:

Buildings	2.5 to 6.67%
Land improvements	2.5 to 20%
Equipment	5 to 33%

Donated capital assets are recorded at their fair value at the date of contribution (if fair value can be reasonably determined.)

e) Inventory

Inventory consists of general stores, pharmacy, laboratory, linen and other. Cost of inventory held is determined on a weighted average basis, except for dietary, linen, laundry, plant maintenance and remote facility inventory which is determined on a first in, first out basis. All inventories are held at the lower of cost or net realizable value.

f) Pension

Employees of the RHA participate in several multi-employer defined benefit pension plans or a defined contribution plan. The RHA follows defined contribution plan accounting for its participation in the plans. Accordingly the RHA expenses all contributions it is required to make in the year.

g) Measurement Uncertainty

These financial statements have been prepared by management in accordance with Canadian generally accepted accounting principles. In the preparation of financial statements, management makes various estimates and assumptions in determining the reported amounts of assets and liabilities, revenues and expenses and in the disclosure of commitments and contingencies. Changes in estimates

and assumptions will occur based on the passage of time and the occurrence of certain future events. The changes will be reported in the period in which they become known.

h) Financial Instruments

The RHA has classified its financial instruments as one of the following categories: held-to-maturity, held-for-trading, loans and receivables, or other liabilities.

All financial instruments are measured at fair value upon initial recognition. The fair value of a financial instrument is the amount at which the financial instrument could be exchanged in an arm's-length-transaction between knowledgeable and willing parties under no compulsion to act. Subsequent to initial recognition, held-for-trading instruments are recorded at fair value with changes in fair value recognized in income. Loans and receivables, held to maturity and other liabilities are subsequently recorded at amortized cost. The classifications of the RHA's significant financial instruments are as follows:

- Cash is classified as held-for-trading.
- Accounts receivable are classified as loans and receivables.
- Investments are classified as held-to-maturity. Transaction costs related to held-to-maturity financial assets are expensed as incurred.
- Short term bank indebtedness is classified as held-for-trading
- Accounts payable, accrued salaries and vacation payable are classified as other liabilities.
- Long-term debt is classified as other liabilities. The related debt premium or discount and issue costs are included in the carrying value of the long-term debt and are amortized into interest expense using the effective interest rate method.

As at March 31, 2010 (2009 – none), the RHA does not have any outstanding contracts or financial instruments with embedded derivatives.

The RHA mitigates risk associated with these financial instruments by purchasing relatively short term low risk investments and classifying those investments as held-to-maturity.

The RHA is exposed to financial risks as a result of financial instruments. The risks the RHA is exposed to are:

i. Price risks which include: Currency risk, affected by changes in foreign exchange rates; Interest rate risk, affected by changes in market interest rates; and Market risk, affected by changes in market prices, whether those changes are caused by factors specific to the individual instrument or the issuer or factors affecting all instruments traded in the market.

ii. Credit risk is the risk that one party to a financial instrument will fail to discharge an obligation and cause the other party to incur a financial loss.

iii. Liquidity risk is the risk that an entity will encounter difficulty in raising funds to meet commitments associated with financial instruments. This may result from an inability to sell a financial asset quickly at close to its fair value.

iv. Cash flow risk is the risk that future cash flows associated with a monetary financial instrument will fluctuate in amount.

The RHA has policies and procedures in place to mitigate these risks.

i) Replacement Reserves

The RHA is required tomaintain certain replacement reserves as a condition of receiving subsidy assistance from Saskatchewan Housing Corporation. Schedule 4 shows the changes in these reserve balances during the year.

3. Capital Assets

	March 31, 2010			March 31, 2009
	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Land	$ 266,556	$ -	$ 266,556	$ 266,556
Land Improvements	488,097	397,464	90,633	96,860
Buildings	42,354,493	30,574,991	11,779,682	11,654,656
Equipment	29,035,575	21,957,551	7,077,724	4,894,815
Construction in progress	23,335	-	23,335	23,565
	$ 72,167,556	$ 52,930,006	$ 19,237,850	$ 16,936,452

4. Commitments

a) Capital Assets Acquisition

At March 31, 2010, commitments for acquisition of capital assets were $1,351,462 (2009 - $1,95,974).

b) Contracted Health Service Operators

The RHA contracts on an ongoing basis with private health service operators to provide health services in the RHA similar to those provided in the year ending March 31, 2009.

5. Mortgages Payable

Title of Issue	Interest Rate	Annual Repayment Terms	Balance Outstanding 2010	2009
Pioneer Housing (Moose Jaw) CMHC, due November 1, 2016	5.38%	$22,877 principal & interest. Mortgage renewal date – November 1, 2016	$128,183	$143,794
Pioneer Housing (Moose Jaw) CMHC, due July 1, 2019	6.88%	$7,229 principal & interest. Mortgage renewal date – July 1, 2019	49,884	953,903
Pioneer Housing (Moose Jaw) CMHC, due September 1, 2027	10.38%	$95,747 principal & interest of which $22,188 is subsidized by SHC. Yielding an effective interest rate of 7.3%. Mortgage renewal date - September 1, 2027.	778,569	9791,653
Regency Manor CMHC, due August 1, 2019	4.37%	$99,550 principal & interest of which $23,203 is subsidized by SHC. Yielding an effective interest rate of 0%. Mortgage renewal date - October 1, 2010.	708,665	9833,575
Assiniboia Pioneer Lodge CMHC, due October 1, 2024	0.00%	$8,503 principal & interest. Mortgage renewal date - October 1, 2024.	94,266	958,259
Assiniboia Pioneer Lodge CMHC, due October 1, 2024	6.00%	$10,561 principal & interest. Mortgage renewal date - November 1, 2008.	155,662	9150,316
			$1,904,867	$2,934,703
Less: Current portion			118,238	$113,196
			$1,786,629	$1,866,563

Saskatchewan Housing Corporation (SHC) may provide a mortgage subsidy for supportive care homes financed by Canada Mortgage and Housing Corporation (CMHC). The subsidy may change when the mortgage renewal occurs.

For each of the mortgages, the RHA has pledged the related buildings of the special care homes as security. Principal repayments required in each of the next five years is estimated as follows:

2011	$ 118,238
2012	124,973
2013	132,150
2014	139,803
2015	147,970
2016 and subsequent	1,241,733

6. Deferred Revenue

	Balance Beginning of Year	Less Amount Recognized	Add Amount Received	Balance End of Year
Sask Health Initiatives				
Saskatchewan Health – General Revenue Fund	$ -	$ -	$ -	$ -
On site Emergency Room Medical Remuneration	307,335	1,750,448	1,797,258	353,845
Work Place Wellness	180,238	187,303	103,116	96,051
Family Support and Rehab	71,457	3,566	-	67,891
Approved homes enhancements	-	19,438	30,840	11,382
[illegible]rgical Access	47,464	-	-	47,464
[illegible] Evaluation	16,110	-	-	16,110
Nursing Council	31,895	19,062	-	12,833
Alt Physician Pymt C Butte	39,285	249,010	482,260	272,535
Alt Physician Pymt Moose Jaw	-	140,998	148,228	7,230
Alt Phys Pymt Tum Wellness	-	4,090	12,196	8,106
Substance Abuse Youth Needs	5,250	5,250	-	-
Profound Development Fund	18,233	20,018	32,695	30,912
Workforce Retention - Cognitive Behavior Therapy	7,083	7,083	-	-
Workforce Retention - Nurse Coordinator/Educator	37,500	37,500	-	-
Workforce Retention - Dementia Care Training	14,694	-	-	14,694
Needle Exchange	56,375	20,175	16,000	52,200
Undersg Medical Remuneration	186,205	-	-	186,205
Primary Health Care Team Facilitator	2,719	2,719	-	-
Primary Health Care Central Butte Site	275,137	324,087	392,600	343,650
Primary Health Care Cmtk	-	130,202	137,600	7,398
Primary Health Care Assiniboia Kincaid	-	205,650	205,650	-
Primary Health Care Moose Jaw	-	7,083	7,083	-
Renal Dialysis Project	86,859	-	-	86,859
Smoke Free Legislation	12,108	12,108	-	-
HIPA Implementation	9,088	1,963	-	7,165
Aboriginal Awareness Training	13,000	5,464	-	7,676
SIMS PHIS	16,483	-	-	16,483
Addictions Cross Training	34,099	66,300	80,000	47,762
Addictions	35,074	132,311	80,000	2,663
Addictions Community Supports	123,132	284,011	239,000	97,121
Dental Student Program	38,587	38,587	-	-
Joint Replacement Surgery – Hip Knee Pathway	392,665	134,967	102,400	360,098
Sahtoot Program Quality Workplace	32,966	731	12,695	45,110
Nursing Education Professional Development RN BSN	16,413	1,078	-	36,737
Nursing Education Professional Development LPN	14,000	7,678	-	7,237
Recruitment initiatives	-	-	30,000	30,000
Nurse Mentorship Initiative	145,933	144,116	115,000	116,127
Safety Training Initiatives (OH&S)	131,363	48,649	37,161	119,880
Addictions Secure Youth Detox	108,119	92,465	101,135	108,024
Public Health Capacity	161,540	-	31,000	192,540

	Balance Beginning of Year	Less Amount Recognized	Add Amount Received	Balance End of Year
Sask Health Initiatives cont'd				
West Nile Virus	2,484	2,484	-	-
CTAS	12,116	12,116	-	-
Infection Control	157,868	109,484	110,000	158,384
Infection Control - Prevention and Control	-	-	65,127	65,127
MDS Home Care	73,580	27,367	-	46,213
Surgical Waitlist Incentive	135,568	46,042	-	89,526
Autism Services	139,912	151,623	166,000	154,289
Physician Funding Kincaid	31,249	58,003	126,048	99,294
Renal Dialysis funding 0809	274,945	-	-	274,945
Integration Training MHAS	25,000	646	-	24,354
New Graduatuate Mentorship	227,884	105,873	-	122,011
Telehealth Expansion Gravelbourg	33,528	-	-	33,528
PT & OT Professional Development	880	880	-	-
Angus Campbell Centre - clinical supervisor	-	-	254,000	254,000
Pandemic H1N1	-	-	236,000	236,000
Paramedic Act Changes	-	-	14,250	14,250
Physician Issues	-	-	100,000	100,000
High Risk Youth	-	190,638	230,776	40,138
2010/11 Biweekly payment advance	-	-	4,472,115	4,472,115
Clinical Conference Mental Health	10,000	10,000	-	-
Total Sask Health	**$ 3,845,425**	**$ 4,819,293**	**$ 9,948,728**	**$ 8,974,860**
Non Sask Health Initiatives				
Sask Learning - General Revenue Fund - Kids First Targeted	$ 93,531	$ 669,000	$ 696,202	$ 120,733
Sask Learning - General Revenue Fund - Kids First Non Targeted	-	71,700	71,700	-
Sask Social Services - General Revenue Fund - Housing Advance	1,940	-	-	1,940
Sask Academic Health Sciences Network (SAHSN) - Preceptor Recognition	-	473	12,750	12,277
University of Sask - pharmacy clinical student program	-	-	5,000	5,000
Immigration Canada - newwcomers population health needs	-	2,840	12,500	9,660
Other - Special Needs	317,458	248,501	198,483	267,440
Other - Career employment services	-	52,500	63,000	10,500
Other - SGI Acquired Brain Injury Prov Coord Adv	22,992	91,965	92,655	23,682
Other - SGI Acquired Brain Injury Comm Coord Adv	19,685	78,741	79,331	20,275
Other - SGI Acquired Brain Injury Independent Living Adv	-	34,481	46,319	11,838
Other - SGI Acquired Brain Injury Comm Coord	18,540	(16,587)	-	35,127
Other - SGI Acquired Brain Injury Independent Living	-	(16,366)	-	16,366

	Balance Beginning of Year	Less Amount Recognized	Add Amount Received	Balance End of Year
Non Sask Health Initiatives Cont'd				
Other - Resource Centre	36,695	-	-	36,695
Mental Health Clinical Conference	31,820	11,247	-	20,573
Other - MJ Health Foundation	20,072	-	-	20,072
Other - Assiniboia Union Hospital	45,997	17,493	-	28,504
Other - Central Butte Regency Hospital	154,949	65,403	43,000	132,546
Other - Craik Health Centre	58,478	18,464	-	40,014
Other - Home Care Palliative	18,673	-	-	18,673
Other - First Nations Health Employer Support	18,451	-	-	18,451
Other - Pioneer Housing MJ Mortlach Mgmt Board	607	-	-	607
Other - Canadian Public Health Association	11,790	-	-	11,790
Other - Sun Partnership Agreement Recruitment Retention	224,925	-	-	224,925
Other - Safe Community Assiniboia	7,341	17,614	17,787	7,514
Other - School Team Social Worker	16,250	16,250	-	-
Other - Community Youth Program	5,000	68,750	85,000	21,250
Other - HQC Pursuing Excellence	-	66,561	116,719	50,158
Other - miscellaneous	11,582	3,196	-	8,386
Total Non Sask Health	**$ 1,136,776**	**$ 1,502,226**	**$ 1,540,446**	**$ 1,174,996**
Total Deferred Revenue	**$ 4,982,201**	**$ 6,321,519**	**$ 11,489,174**	**$ 10,149,856**

Externally restricted revenue, received in the operating fund, is deferred if the restriction has not been fulfilled by the end of the fiscal year.

7. Net Change in Non-cash Working Capital

	Operating Fund		Restricted Funds			
			Capital	Community	Total	Total
	2010	2009	Fund	Trust Fund	2010	2009
(Increase) Decrease in accounts receivable	$ (59,019)	$ 41,701	$ (1,521)	$ 3,597	$ 2,076	$ 14,079
(Increase) in inventory	(276,327)	(6,752)			-	
(Increase) Decrease in prepaid expenses	24,054	(75,710)			-	
Increase (Decrease) in accounts payable	740,207	133,820	(524)		(524)	(483)
Increase in accrued salaries	2,660,266	365,817			-	
Increase in vacation payable	297,752	531,698			-	
Increase in deferred revenue	5,167,655	1,175,821			-	
	$ 8,554,588	$ 2,166,395	$ (2,045)	$ 3,597	$ 1,552	$ 13,596

8. Patient and Resident Trust Accounts

The RHA administers funds held in trust for patients and residents using the RHA's facilities. The funds are held in separate accounts for the patients or residents at each facility. The total cash held in trust as at March 31, 2010 is $4,721 (2009 - $6,161) and are included in the financial statements.

9. Related Party Transactions and Other Third Party Contractors

These financial statements include transactions with related parties. The RHA is related to all Saskatchewan Crown Agencies such as ministries, corporations, boards and commissions under the common control of the Government of Saskatchewan. The RHA is also related to non-Crown enterprises that the Government jointly controls or significantly influences. In addition, the RHA is related to other non-Government organizations by virtue of its economic interest in these organizations.

a) Related Party Transactions

Transactions with these related parties are in the normal course of operations. Amounts due to or from and the recorded amounts resulting from these transactions are included in the financial statements at the standard rates charged by those organizations and are settled on normal trade terms.

In addition, the RHA pays Provincial Sales Tax to the Saskatchewan Ministry of Finance on all its taxable purchases. Taxes paid are recorded as part of the cost of those purchases.

	2010	2009
Revenues		
Workers Compensation	$ 297,497	$ 337,981
Ministry of Learning	739,398	753,013
	$ 1,036,895	$ 1,090,994

	2010	2009
Expenses		
Saskatchewan Association of Health Organizations	$ 3,176,264	$ 2,980,089
Saskatchewan Health Employees Pension Plan	4,188,343	3,114,686
Saskatchewan Energy	509,654	769,047
Saskatchewan Power	734,020	709,184
Ministry of Government Services	456,430	424,431
Sask Tel	249,072	244,258
Valleyview	711,051	680,836
Workers Compensation	1,075,230	1,023,361
	$ 11,100,064	$ 9,945,892
Prepaid Expenditures		
Workers Compensation	$ 255,357	$ 267,414
Saskatchewan Association of Health Organizations	118,710	118,710
	$ 374,067	$ 386,124
Accounts Payable		
Saskatchewan Association of Health Organizations	$ 207,501	$ 197,205
	$ 207,501	$ 197,205

b) Health Care Organizations

i) Prescribed Health Care Organizations and Third Parties

The RHA has also entered into agreements with prescribed HCOs and Third Parties to provide health services.

These organizations receive operating funding from the RHA on a monthly basis in accordance with budget amounts approved annually. During the year, the RHA provided the following amounts to prescribed HCOs and Third Parties:

	2010	2009
Extendicare (Canada) Inc.	$ 6,424,556	$ 5,507,672
Moose Jaw Alcohol and Drug Abuse Society Inc.	1,053,418	967,931
Canadian Mental Health Association	12,406	11,651
Thunder Creek Rehabilitation Association Inc.	658,949	527,046
Lifeline Ambulance Service Inc.	1,395,226	1,441,194
Wald Ambulance Ltd.	-	301,876
Hutch Ambulance Service Inc.	527,798	232,669
	$ 10,072,353	$ 8,990,039

ii) Affiliates

The Act makes the RHA responsible for the delivery of health services in its region including the health services provided by privately owned affiliates. The Act requires affiliates to conduct their affairs and activities in a manner that is consistent with, and that reflects, the health goals and objectives established by the RHA. The RHA exercises significant influence over affiliates by virtue of its material inter-entity transactions. There is also an interchange of managerial personnel, provision of human resource and finance/administrative functions with some affiliates. The following presentation discloses the amount of funds granted to each affiliate:

	2010	2009
Providence Place for Holistic Health Inc.	$ 12,789,275	$ 11,601,957
St. Joseph's Hospital (Grey Nuns) of Gravelbourg	4,778,579	4,338,698
St. Joseph's Hospital (Grey Nuns) of Gravelbourg – Ambulance Service	232,378	238,782
	$ 17,800,232	$ 16,179,437

Saskatchewan Health requires additional reporting in the following financial summaries of the affiliate entities for the years ended March 31, 2010 and 2009.

	Total 2010	Total 2009
Balance Sheet		
Assets	$4,977,390	$4,016,021
Net Capital Assets	24,554,729	25,076,696
Total Assets	$29,532,119	$29,092,717
Total Liabilities	$5,277,612	$4,307,917
Total Net Assets	24,254,507	24,784,800
	$29,532,119	$29,092,717

	Total 2010	Total 2009
Results of Operations		
RHA Grant	$17,776,982	$16,172,215
Other Revenue	4,423,344	4,261,853
Total Revenue	$22,200,326	$20,434,068
Salaries & Benefits	$18,256,259	$15,956,240
Other Expenses*	4,603,779	5,272,698
Total Expenses	$22,860,038	$21,228,938
Excess Revenue over Expenses	($659,712)	($794,870)

* Other Expenses includes amortization of $1,132,076 (2009-$1,127,603)

	Total 2010	Total 2009
Cash Flows		
Cash from Operations	$438,114	($77,191)
Cash used in financing activities	215,295	111,877
Cash used in Investing activities	(215,190)	(111,803)
Increase (decrease) in cash	$438,219	($77,117)

iii) Fund Raising Foundations

Fund raising efforts are undertaken through a non-profit business corporation known as the Moose Jaw Health Foundation (the Foundation). The Five Hills RHA has an economic interest in the Foundation. In 2010 and in accordance with donor-imposed restrictions, $382,669 (2009 - $748,966) of the foundation's net assets must be used to purchase specialized equipment. In 2009, the foundation's total expenses include contributions of $654,365 (2008 - $503,150) to the RHA/community.

10. Comparative Information

Certain 2008-09 balances have been reclassified to conform with the current year's presentation.

11. Pension

Employees of the RHA participate in one of the following pension plans:

1. Saskatchewan Healthcare Employees' Pension Plan (SHEPP) - This is jointly governed by a board of eight trustees. Four of the trustees are appointed by the Saskatchewan Association of Health Organizations (SAHO) (a related party) and four of the trustees are appointed by Saskatchewan's health care unions (CUPE, SUN, SEIU, SGEU, RWDSU, and HSAS). SHEPP is a multiemployer defined benefit plan, which came into effect December 31, 2002. (Prior to December 31, 2002, this plan was formerly the SAHO Retirement Plan and governed by the SAHO Board of Directors).

2. Public Service Superannuation Plan (a related party) - This is a defined benefit plan and is the responsibility of the Province of Saskatchewan.

3. Public Employees' Pension Plan (a related party) - This is a defined contribution plan and is the responsibility of the Province of Saskatchewan.

4. Saskatchewan Municipal Employees Pension Plan (MEPP) (a related party) – This is a defined benefit pension plan and is the responsibility of the Province of Saskatchewan.

The RHA's financial obligation to these plans is limited to making required payments to these plans according to their applicable agreements. Pension expense is included in Compensation – Benefits in Schedule 1 and is equal to the RHA contributions amount below.

	2010					2009
	SHEPP[1]	PSSP	PEPP	MEPP	Total	Total
Number of active members	1,143	1	27	1	1,172	1,157
Member contribution rate, percentage of salary	6.60-9.00%*	7.00-9.00%*	5.00-7.00%*	5.40-5.40%*		
RHA contribution rate, percentage of salary	7.392-10.08%*	25.48-32.76%*	6.00-7.00%*	5.40-5.40%*		
Member contributions (thousands of dollars)	3,380	5	108	4	3,497	2,901
RHA contributions (thousands of dollars)	4,057	21	106	4	4,188	3,269

* Contribution rate varies based on employee group.

1. Active members include all employees of the RHA, including those on leave of absense as of March 31, 2010. Inactive members are transferred to SHEPP and not included in these results. SHEPP contribution rates increased on April 1, 2009 (i.e., from 5.85% to 6.6% and from 7.35% to 9.00% for members; RH contribution rates increased by the same proportion).

12. Budget

The RHA Board approved the 2009-2010 budget plan on May 27, 2009.

13. Financial Instruments

a) Significant terms and conditions

There are no significant terms and conditions related to financial instruments classified as current assets or current liabilities that may affect the amount, timing and certainty of future cash flows. Significant terms and conditions for the other financial instruments are disclosed separately in these financial statements.

b) Credit risk

The RHA is exposed to credit risk from the potential non-payment of accounts receivable. The majority of the RHAs receivables are from Saskatchewan Health - General Revenue Fund, Saskatchewan Workers' Compensation Board, health insurance companies or other Provinces. Therefore, the credit risk is minimal.

c) Fair value

The following methods and assumptions were used to estimate the fair value of each class of financial instrument:

- The carrying amounts of these financial instruments approximate fair value due to their immediate or short-term nature.

  cash and short term investments
  accounts receivable
  accounts payable
  accrued salaries and vacation payable

- For investments, the fair value is based on quoted market values.

- The fair value of mortgages and term loan payable before the repayment required within one year, is $1,937,904 (2009 - $2,034,439) and is determined using discounted cash flow analysis based on current incremental borrowing rates for similar borrowing arrangements.

14. Interfund Transfers

Each year the RHA transfers amounts between its funds for various purposes. These include funding capital asset purchases, and reassigning fund balances to support certain activities.

	2010			2009		
	Operating Fund	Capital Fund	Community Trust Fund	Operating Fund	Capital Fund	Community Trust Fund
Capital asset purchases	$ (1,999,329)	$ 1,999,329	$ -	$ (2,222,732)	$ 2,222,732	$
SHC reserves	(58,349)	58,349	-	(37,939)	37,939	
	$ (2,057,678)	$ 2,057,678	$ -	$ (2,260,671)	$ 2,260,671	$

15. Volunteer Services

The operations of the RHA utilize services of many volunteers. Because of the difficulty in determining the fair market value of these donated services, the value of these donated services is not recognized in the financial statements.

16. Joint Job Evaluation Reconsiderations

The joint job evaluation/pay equity initiative for the service provider unions CUPE, SEIU, and SGEU allowed for an appeal process. As a result, employees and employers filed appeals, and recommendations on these appeals were completed. Major disputes were heard before the JJE Dispute Resolution Tribunal (Tribunal). There still remains a number of individual issues that consist of recommendations that were not agreed to. Outcomes of the Tribunal resulted in further issues where additional classifications were created and duties of existing classifications were revised. A process to deal with the issues is being developed by a 3rd party. Dealing with some of these issues is expected to extend until 2011. The results of outstanding issues are currently unknown. The costs of these cannot be reasonably determined at this time.

17. Collective Agreements

The SEIU contract expired March 31, 2008 and, while the proposed settlement has not been agreed to or ratified by the union, an estimate for the SEIU retroactive settlement of $4,390,000 has been accrued in the financial statements. The HSAS contract expired March 31, 2009 and negotiations are ongoing. An estimate of the settlement is not determinable at this time. The SUN contract is in effect until March 31, 2012.

Schedule 1

FIVE HILLS REGIONAL HEALTH AUTHORITY
SCHEDULE OF EXPENSES BY OBJECT
For the Year Ended March 31, 2010

	Budget 2010	Actual 2010	Actual 2009
Operating:			
Board costs	$ 117,224	$ 101,152	$ 97,432
Compensation - Benefits	10,843,937	11,378,843	9,813,466
Compensation - Salaries	57,034,000	60,605,567	55,303,085
Diagnostic imaging supplies	400,483	268,641	304,493
Drugs	1,619,178	1,392,611	1,291,334
Food	1,180,093	1,186,045	1,131,388
Grants to ambulance services	2,199,825	2,196,907	2,256,026
Grants to third parties	23,316,827	24,802,110	22,497,222
Housekeeping and laundry supplies	529,425	566,769	485,356
Information technology contracts	301,755	313,455	283,041
Insurance	290,464	286,419	238,482
Interest	2,774	218	856
Laboratory supplies	1,143,548	1,078,896	984,668
Medical and surgical supplies	2,201,712	2,059,832	1,704,481
Medical remuneration and benefits	9,147,010	8,956,082	8,703,318
Office supplies and other office costs	469,242	449,220	404,730
Other	1,083,452	1,158,971	1,214,429
Other referred out services	1,730,400	2,134,680	1,865,751
Professional fees	602,717	618,414	646,929
Prosthetics	837,078	647,141	667,514
Purchased services	458,235	500,973	571,686
Rent/lease costs	1,150,140	1,349,320	1,272,361
Repairs and maintenance	716,179	598,617	635,889
Service contracts	824,272	757,232	694,708
Travel	1,104,505	1,028,033	1,075,524
Utilities	1,719,603	1,439,616	1,672,190
	$ 121,024,078	**$ 125,875,764**	**$ 115,816,359**
Restricted:			
Amortization		$ 4,254,713	$ 3,978,043
Loss/(Gain) on disposal of fixed assets		-	-
Mortgage interest		138,036	144,017
Other		723,197	344,693
		$ 5,115,946	**$ 4,466,753**

Schedule 2
FIVE HILLS REGIONAL HEALTH AUTHORITY
SCHEDULE OF INVESTMENTS
As at March 31, 2010

	Amount	Maturity	Effective Rate	Coupon Rate
Restricted Investments*				
Cash and Short Term				
Chequing and Savings:				
Concentra	$ 17,972,563			
RBC Dominion Securities	29,861			
	$ 18,002,424			
Bond/Mutual Fund:				
Province of Saskatchewan	$ 115,100	7/15/2010	2.50%	2.50%
Bank of Nova Scotia GIC	89,338	3/27/2011	4.10%	4.10%
	$ 204,438			
Total Cash & Short Term Investments	$ 18,206,862			
Long Term				
AGF Trust	$ 48,666	6/27/2011	2.15%	2.15%
Royal Bank CPI Notes	520,000	12/5/2012	US CPI + .64%	
ICICI Bank GIC	87,390	6/4/2013	4.68%	4.68%
Province of British Columbia	357,839	8/23/2013	8.50%	6.81%
Province of British Columbia	62,400	8/23/2013	3.90%	3.90%
TD Mortgage GIC	107,250	3/6/2014	3.75%	3.75%
TD Pacific Mortgage GIC	98,480	3/6/2014	3.75%	3.75%
NATCAN	48,666	6/10/2014	3.96%	3.96%
National Bank of Canada	48,666	6/10/2014	3.96%	3.96%
RBC Principle Prot Guaranteed	63,527	12/24/2014	min 1%	min 1%
Ontario Hydro	42,978	8/18/2022	8.90%	8.90%
Total Long Term Investments	$ 1,485,862			
Total Restricted Investments	**$ 19,692,724**			
Unrestricted Investments				
Cash and Short Term				
Chequing and Savings:				
Concentra	$ 23,649,737			
Royal Bank	4,179			
RBC Dominion Securities	9			
Cash on hand	8,845			
	$ 23,662,770			
Bond/Mutual Fund:				
Province of Saskatchewan	$ 62,000	7/15/2010	2.50%	2.50%
Total Cash & Short Term Investments	$ 23,724,770			
Long Term				
ICICI Bank GIC	$ 16,795	6/4/2013	4.68%	4.68%
RBC Principle Prot Guaranteed	14,784	12/24/2014	min 1%	min 1%
Total Long Term Investments	$ 31,579			
Total Unrestricted Investments	**$ 23,756,349**			
Total Investments	**$ 43,449,073**			
Restricted & Unrestricted Totals				
Total Cash & Short Term	$ 41,931,632			
Total Long Term	$ 1,517,441			
Total Investments	**$ 43,449,073**			

* Restricted Investments include:

- Community generated funds transferred to the RHA and held in the Community Trust Fund (Schedule 3); and
- Replacement reserves maintained under mortgage agreements with Canada Mortgage and Housing Corporation (CMHC) and/or Saskatchewan Housing Corporation (an agency of the Ministry of Social Services) (SHC) held in the Capital Fund (Schedule 4).

Schedule 3

FIVE HILLS REGIONAL HEALTH AUTHORITY
SCHEDULE OF EXTERNALLY RESTRICTED FUNDS
For the Year Ended March 31, 2010

COMMUNITY TRUST FUND EQUITY

Trust Name	Balance Beginning of Year	Investment & Other Revenue	Donation	Expenses	Withdrawals	Balance End of Year
Moose Jaw Union Hospital - Haggerty	$ 64,780	$ 1,293	$ -	$ (1,900)	$ -	$ 64,173
Moose Jaw Union Hospital - Elsom/Mutrie	14,020	78	-	-	-	14,098
Craik Health Centre	128,406	662	-	-	-	129,068
Thunder Creek Home Care	817,899	19,397	-	(90,685)	-	746,611
South Country	987	5	-	-	-	992
Total Community Trust Fund	**$ 1,026,092**	**$ 21,435**	**$ -**	**$ (92,585)**	**$ -**	**$ 954,942**

CAPITAL FUND

	Balance Beginning of Year	Investment & Other Income	Capital Grant Funding	Expenses	Transfer to Investment in Capital Asset Fund Balance	Balance End of Year
Ministry of Health - Capital Projects	$ 9,205,574	$ -	$ 688,000	$ -	$ 4,208,509	$ 5,685,065
Moose Jaw Health Foundation - diagnostic imaging	334,021	-	-	-	127,020	207,001
Total Capital Fund	**$ 9,539,595**	**$ -**	**$ 688,000**	**$ -**	**$ 4,335,529**	**$ 5,892,066**

TOTAL EXTERNALLY RESTRICTED REVENUE	**$ 10,565,687**	**$ 21,435**	**$ 688,000**	**$ (92,585)**	**$ 4,335,529**	**$ 6,847,008**

Schedule 4

FIVE HILLS REGIONAL HEALTH AUTHORITY
SCHEDULE OF INTERNALLY RESTRICTED FUND BALANCES
For the Year Ended March 31, 2010

	Balance Beginning of Year	Investment Income Allocated	Annual Allocation (from unrestricted fund)	Operating Expenses	Capital Expenses	Balance End of Year
Capital						
SHC Replacement Reserves						
Assiniboia Pioneer Lodge	$ 231,677	$ 1,200	$ 23,866	$ -	$ -	$ 256,743
Pioneer Housing - Lodge (Moose Jaw)	168,315	900	14,833	-	14,390	169,658
Pioneer Housing - Units (Moose Jaw)	213,291	800	12,000	-	-	226,091
Regency Manor	147,280	750	7,650	-	-	155,680
Total SHC	760,563	3,650	58,349	-	14,390	808,172
Other Internally Restricted Funds						
Grasslands Health Centre Roof - SGI	23,884	-	-	40	-	23,844
RHA cummulative surplus	12,373,170	-	2,057,678	-	2,369,698	12,061,150
Total Capital	**$ 13,157,617**	**$ 3,650**	**$ 2,116,027**	**$ 40**	**$ 2,384,088**	**$ 12,893,166**
Total Internally Restricted Funds	**$ 13,157,617**	**$ 3,650**	**$ 2,116,027**	**$ 40**	**$ 2,384,088**	**$ 12,893,166**

Schedule 5

FIVE HILLS REGIONAL HEALTH AUTHORITY
SCHEDULES OF
BOARD REMUNERATION, BENEFITS AND ALLOWANCES
For the Year Ended March 31, 2010

	2010							2009
RHA Members	Retainer	Per Diem	Travel Time Expenses	Travel and Sustenance Expenses	Other Expenses	CPP	Total	Total
Velma Geddes [1]	$ 9,960	$ 11,763	$ 863	$ 1,379	$ 317	$ 959	$ 25,241	$ 5,353
Dale Toni [3]							-	16,291
							-	-
Alvin Arnold [3]							-	6,720
Grant Berger [1]		4,655	1,317	1,046	692	157	7,867	2,427
John Bumbac [3]							-	9,322
Marian Campbell [3]							-	5,244
Elizabeth Collicott [1]		5,313	275	505	172		6,265	1,802
Clark Coulson [1]		3,825	50	94		85	4,054	1,807
Shayne Cristo [3]							-	4,685
Jo-anne Dusel [3]							-	4,846
David Foley [3]							-	5,904
Leslie Gray [3]							-	6,083
Kenneth Hawkes [1]		5,293	125	176	704	127	6,425	2,344
Alvin, Klassen [1]		4,993	1,450	1,755	534		8,732	2,921
Tracey Kuffner [1]		4,400	2,088	2,672	375	162	9,697	3,154
Betty Michalski [3]							-	-
Elaine Mulatz [3]							-	2,842
Janeth Muldoon [3]							-	9,363
Cecilia Mulhern [1]		5,600	2,750	2,857	669	254	12,130	3,155
Christine Racic [1]		4,605	113	525	400	112	5,755	2,418
George Reaves [1]		5,000	1,950	2,215	669	(59)	9,775	3,196
Jeffrey Reihl [1]		4,650	50			111	4,811	1,834
Donald Shanner [2]		5,405	175	494	375	(48)	6,401	7,596
							-	
							-	
Total	$ 9,960	$ 65,502	$ 11,206	$ 13,718	$ 4,907	$ 1,860	$ 107,153	$ 109,307

(1) appointed Feb 5, 2009
(2) returning health authority member and re-appointed Feb 5, 2009
(3) resigned with the appointment of the new health authority Feb 5, 2009

SENIOR MANAGEMENT SALARIES, BENEFITS, ALLOWANCES AND SEVERANCE
For the Year Ended March 31, 2010

	2010					2009		
Senior Employees	Salaries[1]	Benefits and Allowances[2]	Sub-total	Severance Amount	Total	Salaries, Benefits & Allowances[1,2]	Severance	Total
Dan Florizone, CEO[3]	$ -	$ -	$ -	$ -	$ -	$ 74,658	$ -	$ 74,658
Cheryl Craig, CEO[4]	254,893	6,913	$ 261,806	-	261,806	153,803	-	153,803
Craig Beesley, Exec Dir	122,884	-	$ 122,884	-	122,884	119,508	-	119,508
Nola Ayers, Exec Dir[5]	150,648	-	$ 150,648	-	150,648	122,662	-	122,662
Amanda Zarubin, Exec Dir[6]	7,398	-	$ 7,398	-	7,398	40,916	-	40,916
Wayne Blazieko, Exec Dir & CFO	139,451	-	$ 139,451	-	139,451	145,389	-	145,389
Dr. Mark Vooght, MHO	218,594	-	$ 218,594	-	218,594	215,680	-	215,680
Terry Hutchinson, Exec Dir	125,950	-	$ 125,950	-	125,950	121,234	-	121,234
Dianne Ferguson, Exec Dir	108,607	-	$ 108,607	-	108,607	105,361	-	105,361
Dr. Tyrone Josdal, Medical Director[7]	-	-	$ -	-	-	22,127	-	22,127
Dr. Ramadan, interim Med Director[8]	50,000	-	$ 50,000	-	50,000	74,839	-	74,839
Dr. George Carruthers, Medical Director[9]	109,275	-	$ 109,275	-	109,275	-	-	-
John Liguori, Exec Dir	125,499	-	$ 125,499	-	125,499	121,304	-	121,304
Laurie Albinet - Exec Dir[10]	118,021	-	$ 118,021	-	118,021	67,774	-	67,774
Gilbert Linklater, Exec Dir	140,310	-	$ 140,310	-	140,310	132,460	-	132,460
								-
Total	$ 1,671,530	$ 6,913	$ 1,678,443	$ -	$ 1,678,443	$ 1,517,715	$ -	$ 1,517,715

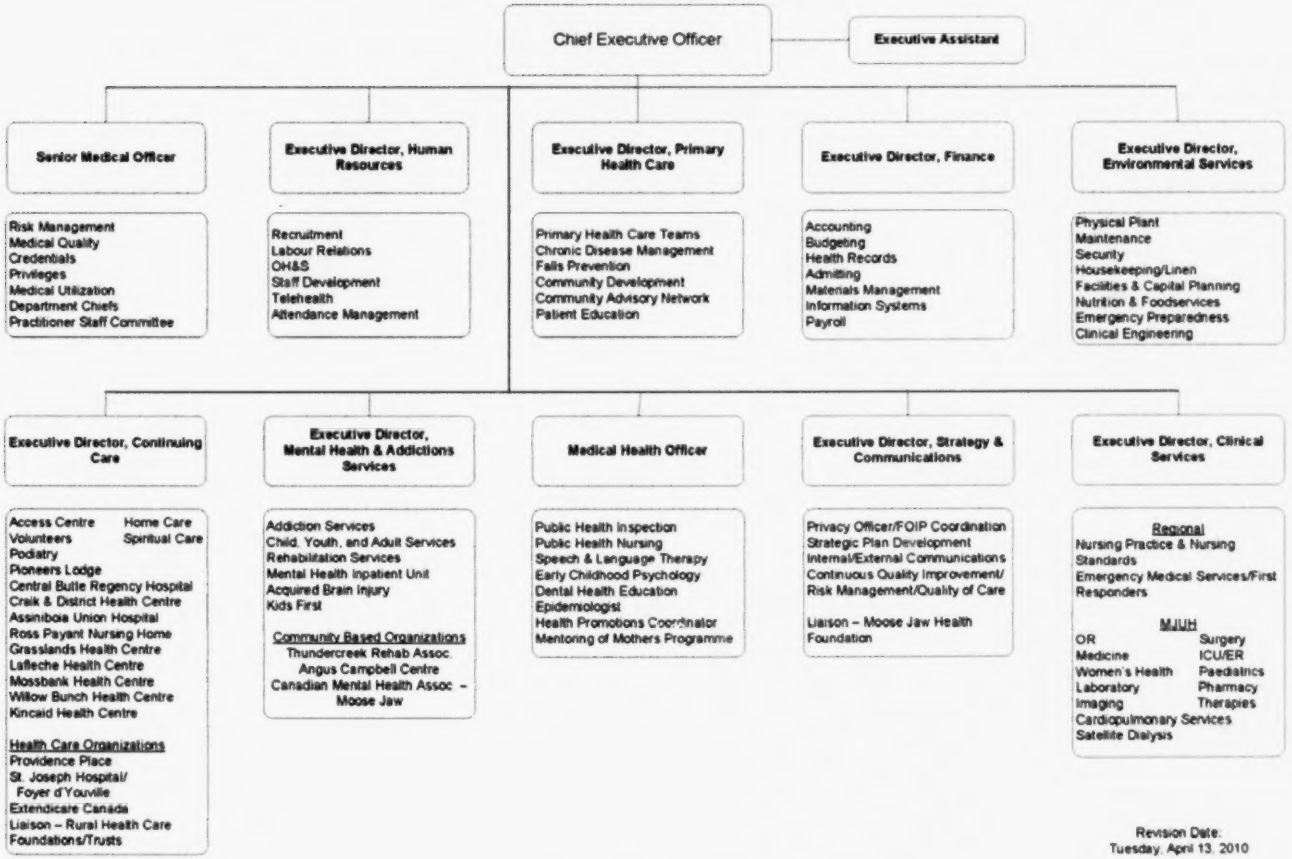
1. Salaries include regular base pay, overtime, honoraria, sick leave, vacation leave, and merit or performance pay, lumpsum payments, and any other direct cash remuneration.
2. Benefits and Allowances include the employer's share of amounts paid for the employees' benefits and allowances that are taxable to the employee. This includes taxable: professional development, education for personal interest, non-accountable relocation benefits, personal use of: an automobile; cell-phone; computer; etc. As well as any other taxable benefits.

3. Dan Florizone - resigned Jul 31, 2008.
4. Cheryl Craig - interim Chief Executive Officer Aug 1, 2008 and permanent Apr 29, 2009 (received vacation payout 09/10).
5. Nola Ayers - Human Resources Executive Director resigned Mar 31, 2010.
6. Amanda Zarubin - interim Human Resources Executive Director July 23, 2008 to Jan 1, 2009 & permanent Mar 8, 2010.
7. Dr. Tyrone Josdal - resigned Jun 30, 2008.
8. Dr. Fauzi Ramadan - interim Medical Director Aug 17, 2008 to Aug 31, 2009.
9. Dr. George Carruthers - medical director Oct 15, 2009.
10. Laurie Albinet - interim Clinical Services Executive Director Aug 1, 2008 & permanent Aug 25, 2009.

Appendix A
The Four Pillars

Strategic Focus	1. HEALTH OF THE INDIVIDUAL	2. PROVIDERS	3. SUSTAINABILITY	4. HEALTH OF THE POPULATION
Goals	1.1 The health system and its employees / providers are focused on providing exceptional care and service to its customers that is consistent with both best practice and customer expectations	2.1 Health service providers have a personal commitment and ownership in creating and working in a caring and high performance environment	3.1 There is strategic and operational alignment of priorities within the health system and with the goals and priorities of Government	4.1 Health promotion / protection and disease prevention initiatives improve the health of the population and reduce disparities
	1.2 People have timely access to appropriate and quality health services and supports	2.2 The health system has safe, supportive, and quality work places	3.2 The health system has the required equipment, capital, and electronic infrastructure	4.2 Long-term strategies address the social factors that impact people's health
	1.3 The system works to continuously improve health care safety	2.3 The health sector has a highly skilled, professional and diverse workforce with a sufficient number and mix of service providers		

Appendix B
Organizational Chart



Appendix C
Community Advisory Networks

Communities and organizations our health region currently interacts include, but are not limited to:

Assiniboia Civic Improvement Association
Assiniboia Union Hospital Auxiliary
Badlands Recreational Committee
Briercrest College
Canadian Cancer Society
Canadian Diabetes Association
Cayer Trust (Willow Bunch)
Central Butte and District Foundation
Central Butte Union Hospital Auxiliary
Child Action Committee (Moose Jaw)
Child Action Group (Assiniboia)
Child and Youth Interagency Committee
Cosmo Senior Citizen's Centre
Craik and District Foundation
Craik Auxiliary
Department of National Defense 15 Wing
Division scolaire francophone 310
Elbow Auxiliary
Emergency Measures Organizations
Emergency Response Planning Committee
Eyebrow Auxiliary
File Hills Tribal Council
Food Security Network
Grasslands Trust Fund Corp.
Grasslands Health Centre Auxiliary
Holy Trinity Roman Catholic Separate School Division No. 22
Housing Authorities
John Howard Society
Kincaid & District Health Centre Board Inc.
Lafleche District Health Foundation Inc.
Ludlow Trust
Medical Advisory Committee
Metis Nation
Moose Jaw & District Senior Citizens Association
Moose Jaw and District Interagency Committee
Moose Jaw Families for Change
Moose Jaw Health Foundation
Moose Jaw Mental Health Housing Committee
Moose Jaw Union Hospital Auxiliary
Mossbank Trust
Municipal Governments
Pioneer Lodge Assiniboia Auxiliary
Prairie South School Division No. 210
Regency Hospital Auxiliary
Regional Economic Development Authorities – Moose Jaw, Assiniboia, Red Coat
Regional Intersectoral Committee
Ross Payant Nursing Home Auxiliary
SIAST - Palliser Campus
South Central Recreation and Parks Association
South Country Health Care Foundation
Thunder Creek Rehabilitation Association
Transition House
Tugaske Auxiliary
Unions
Valley View Centre